# Lexhill Limited - Kaikohe Care

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Lexhill Limited

**Premises audited:** Kaikohe Care

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

**Dates of audit:** Start date: 5 September 2019 End date: 6 September 2019

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 42

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Kaikohe Care Centre is certified to provide rest home, hospital (geriatric and medical) and dementia levels of care for up to 57 residents. On the day of the audit there were 42 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 are required around quality improvement data, corrective action planning, education and training, and building maintenance.

## 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. |

Information about the 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, complaints, advocacy and informed consent. Residents are encouraged to maintain links with the community. A complaints process is implemented.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Services are planned, coordinated, and are appropriate to the needs of the residents. The facility manager and a charge nurse 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. A health and safety programme is being implemented.

Appropriate employment processes are adhered to and employees have a staff appraisal completed on an annual basis. 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. |  | Standards applicable to this service fully attained. |

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior medication competent healthcare assistants are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The diversional therapists implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary needs are recorded. Residents commented positively on the meals. Snacks are available at all times. The food control plan has been verified.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are three double rooms and the rest are single occupancy. Two rooms have ensuites, the rest share communal showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

## 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. |

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. One resident was using bedrails as a restraint and no residents were using enablers.

## Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

## 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 | 47 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 4 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Code of Health and Disability Consumers’ Rights (the Code) brochures are accessible to residents and their families. The policy relating to the Code is implemented and ten care staff interviewed (four healthcare assistants, two registered nurses (RNs), one diversional therapist, one laundry coordinator, one cook, one maintenance) could describe how the Code is incorporated into their job role and responsibilities. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme (link 1.2.7.5). |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all seven resident files reviewed (two rest home, three hospital and two dementia). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is retained in the administration office. The EPOAs of the dementia residents reviewed have been activated. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) office is included in the resident information pack that is provided to new residents and their family on admission. HDC advocacy brochures are also available. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.  Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints, are available at the entrance to the facility.  Information about the complaints process is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints.  A complaints register is maintained. Complaints are acknowledged, investigated and signed off as evidenced on the complaints register. Nine complaints have been lodged in 2019 (year-to-date). Two complaints were reviewed in detail. One complaint, lodged with HDC in 2018, has been signed off by HDC with evidence of corrective actions being implemented. The second complaint, lodged and investigated by the DHB in July 2019, has corrective actions that have not been documented as implemented (link 1.2.3.8). |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information 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 resident/family meetings. All ten residents (five rest home level and five hospital level) and two family (dementia level) interviewed reported that the residents’ rights were being upheld by the service. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The residents’ personal belongings are used to decorate their rooms. Privacy signage is on communal toilet and shower doors. Curtains are installed for visual privacy in the three double (shared) rooms. Residents consent before occupying a shared room.  The healthcare assistants 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. The residents and families interviewed confirmed that residents’ privacy is respected.  Guidelines on abuse and neglect are documented in policy and are covered in staff training (link 1.2.7.5). No instance of suspected abuse or neglect has been reported since the last audit. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Cultural policies are in place. Signage in English and te reo Māori 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 17 residents living at the facility who identified as Māori. One Māori resident interviewed (rest home level) reported that their cultural needs were being met by the service.  Māori consultation is available through links with local Māori community organisations and Māori staff.  Staff have completed cultural competency online training. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and desires from the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Residents and families interviewed confirmed they were involved in developing the resident’s plan of care. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Professional boundaries and the code of conduct are discussed with each new employee during their induction to the service, evidenced in all eight staff files reviewed. Professional boundaries are described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the healthcare assistants’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions (link 1.2.7.5), staff meetings, and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | 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.  Residents and families interviewed reported that they were satisfied with the services received. The 2019 resident/family satisfaction survey results reflected residents who are satisfied or very satisfied (sample = seven residents). The service receives support from the district health board (DHB), which includes (but is not limited to) specialist visits. Physiotherapy services are available two hours per week. Podiatry services are six weekly and hairdressing services are on site once per week. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes a range of information regarding the scope of services provided to the resident on entry to the service, and any items they have to pay for that are not covered by the agreement. Regular contact is maintained with families including when an incident or care/health issues arises, evidenced in the 10 accident/incident forms that were randomly selected for review. Interviews with families confirmed that they are kept informed. The information pack is available in large print and can be read to residents.  Interpreter services are available through the DHB if required. The facility manager reported that this has not been necessary. There were no residents at the facility who did not speak English. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Kaikohe Care Centre provides rest home, hospital (geriatric and medical) and dementia levels of care for up to 57 residents. On the day of the audit there were 42 residents in the care centre (17 at rest home level, 19 at hospital level and 6 at dementia level). All residents were on the aged residential care contract (ARCC).  An experienced facility manager/RN is responsible for day-to-day operations. She began work at this facility in February 2019 and has worked for many years in aged care, both in clinical and managerial roles.  Business goals are in place with evidence of regular reviews with the business owner.  The facility manager has plans to attend a minimum of eight hours annually of professional development activities related to managing an aged care facility. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The facility manager lives on the grounds of the facility Monday – Friday. A charge nurse/RN is responsible for the care centre during any absence of the facility manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | A quality and risk management programme is documented. Quality and risk systems are overseen by the facility manager. New policies and procedures, purchased from an external contractor, have been implemented since the facility manager has been employed. Policies are available for staff to read and sign that they have read and understand the procedures.  Quality and risk data (eg, residents’ falls, skin tears and pressure injuries) are documented, but are not currently being collated, analysed or trended. Infection control data is collated and trended. Quality results, including corrective action plans are not consistently communicated to staff, evidenced in interviews with staff and in staff meeting minutes.  An internal audit schedule is in place with evidence of audits being completed as per the schedule. Corrective actions are identified on each audit form, but this documentation does not support the implementation of corrective actions where opportunities for improvements are identified.  Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls, the use sensor mats and the availability of physiotherapy services two hours per week. Hip protectors are used to help prevent harm from falls.  The health and safety programme is overseen by a health and safety officer who is the maintenance officer. A health and safety induction programme is in place for staff and contractors. Hazard identification forms and hazard registers are implemented with evidence of the hazard registers (hazardous substances, general hazards) last reviewed on 4 July 2019 and 7 March 2019 respectively. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff complete an incident/accident form on an electronic database. Immediate actions and an investigation by an RN (clinical events) are documented. The ten accident/incident forms reviewed indicated that they were completed in their entirety. Neurological observations are undertaken if there is a suspected injury to the head.  Discussions with the facility manager confirmed her awareness of statutory requirements in relation to essential notification. This has been completed for one grade three pressure injury and for one instance where the facility manager covered a night shift due to an RN staff shortage. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Job descriptions are in place that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses and other health professionals were current. Eight staff files were reviewed (two healthcare assistants, one charge nurse/RN, three staff RNs, two cleaners). Evidence of signed employment contracts and job descriptions were sighted. Annual performance appraisals were completed for staff who had been employed for over one year. Newly appointed staff have an orientation that is specific to their job duties.  The service has a training policy and schedule for in-service education. Attendance rates for mandatory education are below 50%. In-service education has not addressed specific recommendations related to a complaint investigated by the DHB.  All thirteen HCAs working in the dementia unit have their dementia qualification. There is a minimum of one staff available 24 hours a day with a current CPR/first aid certificate.  Competencies for RNs include medication competencies and syringe driver competencies. Three of nine RNs have completed their interRAI qualification. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. An RN is scheduled 24 hours a day, seven days a week. In addition to a staff RN available 24/7, a charge nurse is on site three days a week (filled by two RN staff). Two staff RNs are scheduled on the weekend AM shift with the second RN rostered 0700 – 1300).  The facility manager is an RN who assists if needed with clinical responsibilities to cover an unexpected absence. She has needed to cover one (night) shift and approximately 11 or 12 other AM or PM shifts. She lives on the premises five days a week.  The rest home only wing (occupancy 17 residents) is staffed with one long (eight hours) and one short shift HCA (till 1100) on the AM shift, one long HCA on the PM shift and one long HCA on the night shift. Staff from the hospital wing assist as needed.  The rest home/hospital wing (occupancy 19 hospital level residents) is staffed with two long and one short (till 1300) HCA on the AM shift, two long HCAs on the PM shift and one long HCA on the night shift.  The dementia unit (occupancy six residents) is staffed with two long shift HCAs on the AM shift, one long and one short shift (till 2000) HCAs on the PM shift and one HCA on the night shift. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident’s individual record. An initial support plan is also developed in this time.  An electronic clinical record was recently introduced (February 2019). Systems are in place for back-up using cloud-based technology.  Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Hard copy residents’ files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked area.  Residents’ files demonstrated service integration. Entries are legible, dated, timed and signed by the relevant HCA or RN, including designation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the ‘yellow envelope’ transfer system. Communication with family is made. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were two residents self-administering on the day of audit. A consent form had been signed and the resident deemed competent to self-administer. The nasal spray and inhaler were in a drawer. There were no standing orders. There were no vaccines stored on site.  The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs administer all medications. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the hospice. The medication fridge temperature is checked weekly. Eye drops were dated once opened.  Staff sign for the administration of medications on the electronic system. Sixteen medication charts were reviewed (six rest home and ten hospital). Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. ‘As required’ medications had indications for use charted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service has a head chef who works Monday-Friday 0600-1430. There are three other cooks (Monday-Friday 0600-1430, Tuesday-Saturday 0900-1830 and Sundays). There are four kitchenhands who work on a rostered system. There are two cleaners who do the entire kitchen cleaning (link 1.2.7.5). All cooks have current food safety certificates. The head chef oversees the procurement of the food and management of the kitchen.  There is a well-equipped kitchen and all meals are cooked on site. Meals are served in each area from hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well-presented, although resident meeting minutes reflected that the soup is cold in the evenings (link 1.2.3.8). There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents’ dietary needs had been communicated to the kitchen. Special diets and likes and dislikes were noted. The four weekly menu cycle is approved by a dietitian. Snacks are available at all times. All resident/families interviewed were satisfied with the meals.  The food control plan was verified on 11 July 2018. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but not limited to) nutrition, pain, behaviour and continence. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed, evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs and provided detail to guide care. Short-term care plans were in use for changes in health status. These had recently been reviewed and now provide more detailed short-term care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, district nurse and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow. |
| 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 changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative’s health status. Care plans sampled had interventions documented to meet the needs of the residents and there is documented evidence of care plans being updated as residents’ needs changed.  Resident falls are reported on accident/incident forms and written in the progress notes. Neurological observations are taken when there is a head ‘knock’ or for an unwitnessed fall.  Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.  Wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently four wounds being treated including one pressure injury. The pressure injury is a stage two. It was reported on a S31 as it was originally a stage three.  Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. HCAs document changes of position on turning charts. Some forms are electronic, and some are still paper based. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There are two diversional therapists (DT) one of whom works eleven hours a week and the other sixteen and a half. Both work across all areas.  There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents’ needs. These include exercises, bingo, news from the paper, music, quizzes and games. The programme in the dementia unit is flexible, according to mood and energy. Residents in all areas combine for some activities.  Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.  There is a Baptist church service every Saturday morning and Mass every Friday. Every third Sunday the Māori Anglican church visits.  The facility does not have a van, but does hire one occasionally to take residents shopping, for a drive or for a picnic.  Special events like birthdays, Easter, Mothers’ Day, Anzac Day and Melbourne Cup are celebrated. Happy hour is fortnightly. There are regular entertainers.  Two residents have their own cat and families bring animals in to visit.  There is community input from pre-schools, schools and kapa haka groups. A volunteer comes in weekly to play music and tell stories.  Residents have an activity assessment completed over the first few weeks following admission that describes the resident’s past hobbies and present interests, career and family. Resident files reviewed identified that the individual activity plan is based on this assessment. Dementia residents have 24-hour activity plans. Activity plans are evaluated at least six monthly and the DT is gradually trying to complete these at the same time as the review of the long-term care plan.  Resident meetings are held monthly. Residents confirmed they enjoyed the activity programme offered. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are informed of any changes to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to DHB clinics, mental health services for older people and the diabetic nurse specialist. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas. Safety data sheets and product sheets were available. Sharps containers were available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles were available for staff. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building holds a current warrant of fitness which expires 30 June 2020. There is a maintenance person who works 37 hours a week. The lawns are mowed by a contactor. Contracted plumbers and electricians are available as required. There is a reactive and preventative maintenance plan. However, there were areas in resident rooms such as peeling wallpaper and paintwork that require repair. The dementia unit has a strong smell of urine, confirmed when on site and during an interview with family  Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges, hallways and bedrooms are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. The dementia unit has a large enclosed garden. There is safe access to all communal areas.  HCAs and RNs interviewed, stated they have adequate equipment to safely deliver care. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All rooms have hand basins. One room in the rest home and one in the hospital have an ensuite. In the hospital, two rooms share a bathroom and toilet. All other rooms share communal shower/toilet facilities. Fixtures, fittings and flooring are appropriate (link 1.4.2.1). Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are signs on all shower/toilet doors. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There are three double rooms but currently being used as single rooms. All three double rooms have curtains for privacy. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are large and small lounges. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. The dining rooms are spacious. There is a hairdressing salon. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is done on site. There is a laundry worker who works five hours a day, Monday-Friday. A cleaner covers weekends. The laundry is divided into a dirty and clean area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. All chemicals on the cleaner’s trolley were labelled. There are sluice rooms in each area for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are kept closed when not in use. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills are scheduled every six months. The orientation programme and annual education and training programme include fire and security training (link 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. During the audit a fire alarm was activated and responded to by the fire department. Fire cells were sealed promptly, and staff were observed responding quickly and appropriately. The fire warden donned a high visibility vest. (Note: it was a false alarm).  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.  The call bell system has recently been upgraded. Residents were observed in their rooms with their call bell alarms in close proximity.  There is a minimum of one staff available 24/7 with a current first aid/CPR certificate. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas have ample natural light and ventilation. There is electrical heating. Staff and residents interviewed stated that this is effective. There are designated outdoor areas where residents smoke. All other areas are smoke free. Smoking cessation programmes have been offered by the facility. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | There is an infection control coordinator (charge nurse) who is responsible for infection control across the facility. The coordinator liaises with and reports to the facility manager and the infection control team (RNs, HCAs, laundry worker, cleaner and cook). The responsibility for infection control is described in the job description. The coordinator collates monthly infection events and reports. The infection control programme is reviewed annually by the IC coordinator and the facility/manager.  Visitors are asked not to visit if unwell. Hand sanitisers are available. Residents are offered the annual influenza vaccine. There have been no outbreaks. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The IC coordinator is a very experienced RN. She has access to infection control expertise within the DHB, public health, and laboratory. The GP monitors the use of antibiotics. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies were developed by an external quality specialist. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The IC coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have participated in IC education in the last year and there has been one session on hand hygiene in 2019 and another IC session is planned. Resident education occurs as part of providing daily cares and as applicable at resident meetings. The IC coordinator has completed the Ministry of Health’s online IC training and has another IC study day planned. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have generally been low. Trends are identified by the IC coordinator. The facility manager is currently in the process of joining the Far North quality and benchmarking group. Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. One resident (hospital level) was using bedrails as a restraint and no residents were using an enabler. Restraint minimisation training for staff is available and includes staff completing a competency questionnaire. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | A restraint approval process and a job description for the restraint coordinator are in place. Restraint minimisation policies and procedures describe approved restraints. An RN is the designated restraint coordinator. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Restraint assessments are based on information in the resident’s care plan, discussions with the resident and family, and observations by staff. A restraint/enabler assessment tool is being implemented.  The hospital level resident’s file where restraint was being used was reviewed. A restraint assessment and consent for use of the restraint was documented. The assessment included the identification of any risks associated with the use of restraint. Restraint use was linked to the resident’s care plan and again included risks associated with the restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A restraint register is in place. The register identifies the residents that are using a restraint, and the type of restraint used. The restraint assessment reviewed identified that restraint is being used only as a last resort. The facility is aiming towards becoming restraint free.  The frequency of monitoring the resident using restraint was completed two-hourly. Monitoring forms were completed accurately. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint use is evaluated three-monthly by the restraint coordinator. The restraint file reviewed reflected evidence of this. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint programme, including reviewing policies and procedures, the review of any incidents and accidents relating to restraints and evaluating the staff education programme on restraint minimisation, was last completed on 19 June 2019. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Collating, analyses and evaluation of quality and risk data is not being implemented. Quality results are not communicated to staff. Plans are in place to benchmark results against other Northland aged care facilities.  Internal audits are completed, but outcomes are 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 are identified (link 1.2.3.8). | (i) Quality and risk data (eg, falls, skin tears) is not being collated, analysed and evaluated.  (ii) Meeting minutes and interviews with staff do not indicate quality and risk results are communicated to staff. | (i) Ensure quality and risk data is collated, analysed and evaluated each month to identify areas for improvements.  (ii) Ensure quality and risk data results are communicated to staff.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Processes around documenting and implementing corrective actions are not embedded into practice. | There were a sample of corrective actions identified that have not been implemented. For example, corrective actions determined from complaints received (eg, training staff on the identification of pressure injuries, activation of EPOA, evaluating the electronic clinical record system), corrective actions determined from internal audit results (eg, challenging behaviours, cleaning, laundry), and corrective actions determined from resident meetings (eg, three consecutive sets of meeting minutes that indicated the soup served during the evening meal was cold). | Ensure that corrective actions identified are implemented and signed off to indicate their effectiveness.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | An education and training programme is being implemented that includes in-service and online training but attendance rates for mandatory in-service training are below 50%. Online training completion reports were not available.  Seventeen residents identified as Māori but there was no evidence of staff completing cultural training. Nor is there evidence of chemical safety training being available for applicable staff. | (i) The in-service education and training provided for staff reflected low attendance rates with attendance consistently below 50%. Online training did not reflect which staff have completed the modules being offered.  (ii) RNs are frequently recruited from overseas. The RNs interviewed stated that they had not received any cultural training relating to Māori values and beliefs. (Note: There are 17 residents at the facility that identify as Māori). The facility manager confirmed cultural training has been offered as online training, but staff have not completed this module. Values and beliefs for Māori are also not identified in the applicable residents’ long-term care plans (link 1.3.5.2). Since the draft report the provider has confirmed 13 staff have completed MOH Foundations in Cultural competency (certificates sited).  (iii) Cleaners interviewed confirmed that they have not had chemical safety training. This is available as online training, but applicable staff have not completed this module. Since the draft report the provider has confirmed relevant staff have completed chemical safety training.  (iv) DHB corrective actions around staff training on areas related to a previous complaint (eg, enduring power of attorney activation, pressure injury management) have not been documented as implemented. Since the draft report the provider has confirmed 25 staff have completed EPOA, and pressure injury training on 11th & 18 September. | (i) Ensure staff attend all mandatory education and training.  (ii) Ensure Māori cultural training begins during the new staff induction and continues regularly. This is especially important for RN staff who arrive to work at the facility from overseas.  (iii) Ensure staff who handle chemicals participate in chemical safety training.  (iv) Ensure specific training identified as per DHB recommendations are implemented.  60 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | There is a reactive and preventative maintenance plan being implemented. There were areas in resident rooms such as peeling wallpaper and paintwork that require repair. The dementia unit has a strong smell of urine, confirmed when on site and during an interview with family. The facility has new lighting, chairs, and bedspreads. A new call system has been installed. | (i) The environment has areas that require repair, including peeling wallpaper, ceilings that need painting and painting that is chipped and peeling.  (ii) The dementia unit has a strong smell of urine (advised that since the audit the service has removed the pad bin which was the main source of the smell). | (i) Ensure all areas (eg, resident bedrooms) that require repair are addressed.  (ii) Ensure the dementia unit has a fresh and clean odour.  180 days |

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

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

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

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

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End of the report.