

# Lexall Limited - Lexall Care

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## Introduction

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

The audit has been conducted by 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:** Lexall Limited

**Premises audited:** Lexall Care

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

**Dates of audit:** Start date: 9 December 2019      End date: 10 December 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:** 51

# Executive summary of the audit

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## Introduction

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

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

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

## Key to the indicators

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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Lexall Care is privately owned. The service is certified to provide rest home and hospital (medical and geriatric) level care for up to 58 residents. On the day of the audit, there were 51 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The service is managed by a full time experienced clinical manager who has been in the role for over 17 years. The clinical manager is also supported by an administration/finance manager and a general manager (owner), who purchased the facility in 2001.

The service has an established quality and risk management system. Residents and families interviewed commented positively on the standard of care and services provided at Lexall Care.

Three of the four shortfalls identified as part of the previous audit have been addressed. These were around; internal audit follow-up and sign off, staff orientation and water temperatures.

Further improvements continue to be required around medication management.

## 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.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Lexall Care have a documented quality and risk management system. Annual surveys and quarterly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. There is an in-service training programme covering relevant aspects of care. There is a staffing policy in place.

## 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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Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a documented medication management policy and procedure that align with guidelines. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the activities' person. All meals are prepared on site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated, and the residents and relatives reported satisfaction with the food service.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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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. There were four residents requiring the use of restraints and 14 residents using an enabler at the time of audit.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

## 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	15	0	0	1	0	0
Criteria	0	40	0	0	1	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

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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
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff interviewed (two RNs, three caregivers, a cook and an activities person) were aware of the complaints process and to whom they should direct complaints. An electronic complaints register has been maintained. There have been eight complaints received in 2019 year-to-date. One complaint was originally sent to the Health and Disability commission. The Health and Disability commission referred the complaint back to the service. The advocacy service assisted the complainant and the service with the complaint which has now been signed off. There is a further complaint from the same complainant and a social worker is assisting with this complaint.</p> <p>There was documented evidence of response, follow-up and resolution to the complaints reviewed. Two hospital and one rest home resident, and family members advised that they are aware of the complaints procedure and how to access forms.</p>
Standard 1.1.9: Communication  Service providers communicate effectively	FA	<p>There is a policy to guide staff on the process around open disclosure. The clinical manager confirmed family are kept informed. Two hospital relatives interviewed stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Three monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required.</p>
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Lexall Care is privately owned. The service is certified to provide rest home and hospital (medical and geriatric) level care for up to 58 residents. On the day of the audit, there were 51 residents. Seventeen residents were at rest home level of care (including one on a long-term support chronic health conditions contract (LTS-CHC) and two ACC residents) and 34 were at hospital level (including three on a LTS-CHC contract and two DHB Interim funding contract funded residents). All other residents were under the age-related residential care services agreement. Six beds are dedicated as rest home only and the remaining 52 beds are dual-purpose.</p> <p>The service is managed by a full time experienced clinical manager/RN who has been in the role for over 17 years. She is supported by a charge nurse who has been in the position for four years. The clinical manager is also supported by an administration/finance manager and a general manager (owner).</p> <p>The service has a business plan, which is reviewed annually. The business plan identifies the purpose, values and scope of the business. The service has quality goals, which have been reviewed regularly. The clinical manager reported that she meets with the general manager (owner) regularly and that meetings include reviewing the strategic goals. The clinical manager has maintained a minimum of eight hours relating to managing an aged care service.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality and risk management programme are documented and fully implemented which has been purchased from an external consultant. A document control system is in place and policies and procedures were all up to date. New policies or changes to policy are communicated to staff in staff meetings. Quality data is collected for adverse events including (but not limited to) falls and skin tears, pressure injuries, and infections. This data is collated, trended and analysed and is regularly communicated to staff at the quality assurance and quarterly staff meetings. Required actions and resolutions from facility meetings are documented. Minutes of these meetings are made available to all staff.</p> <p>Internal audits are completed as documented according to the audit schedule. Corrective actions have been consistently documented and followed up when internal audit findings are identified. This is an improvement from the previous audit. Annual surveys are completed with the most recent documented during April 2019. Corrective actions have been documented and followed up. The survey results have been communicated to residents and family, such as posters informing residents and families how to access the complaints process. This is also an improvement from the previous audit. Additional surveys include six-week post admission</p>

		<p>surveys for long-term residents and six-week post discharge surveys for short-term residents.</p> <p>A health and safety programme is in place that meets legislative requirements. The clinical manager is the health and safety representative (interviewed). Health and safety is discussed at the monthly quality assurance meeting. Hazard identification forms and a hazard register reflect the regular monitoring of hazard controls. Staff education, which begins during their induction to the service, includes the topic of health and safety. Falls prevention strategies include the use of sensor mats and implementing strategies for frequent fallers.</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 incident and accident data on forms and enters them into an electronic register. The system provides reports monthly, which are discussed at the quality assurance meetings.</p> <p>Eight incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The caregivers interviewed could discuss the incident reporting process. The clinical manager collects incident forms, investigates and reviews and implements corrective actions as required.</p> <p>The clinical manager is aware of the responsibility to notify relevant authorities in relation to essential notifications. There has been one section 31 notification made since the last audit for a stage three pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (two RNs and three caregivers). All files contained relevant employment documentation including current performance appraisals and completed orientations. Current practising certificates were sighted for the registered nurses. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care. This is an improvement from the previous audit.</p> <p>Staff interviewed believed new staff are adequately orientated to the service on employment.</p> <p>There is an annual education and training schedule that is being implemented. Education and training for the RNs is supported by the DHB. There are 11 RNs (including the clinical manager and charge nurse) and three have completed interRAI training. Medication competencies are up to date. Current annual practising certificates were sighted for the registered health professionals. There is a minimum of one staff member available 24/7 with a current first aid/CPR certificate.</p>

<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A staffing plan is documented for the service. The clinical manager and charge nurse are available five days a week (Monday to Friday) and are on call 24/7. The facility is split in to five wings.</p> <p>In wings one, two and three (upstairs) there were 13 rest home and 19 hospital level residents. There is one RN on duty on the morning and afternoon shifts. There are three caregivers on the morning and three for the afternoon shifts.</p> <p>In wings four and five (downstairs) there were four rest home and 15 hospital level residents. There is one RN on duty on the morning and afternoon shifts. There are three caregivers on the morning and three for the afternoon shifts.</p> <p>The night shift includes one RN and three caregivers for the facility.</p> <p>Staff working on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff that administer medications (RNs and occasionally some senior caregivers) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the electronic medication chart. All medications are stored securely in the two medication rooms (one upstairs and one downstairs). The medication fridges are maintained within the acceptable temperature range as have the two medication rooms. Regular temperature monitoring of fridges and the rooms are documented. There was one self-medication resident, all assessments were in place and the medication was stored safely.</p> <p>Ten medication charts reviewed met legislative requirements. Medications had been signed as administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication round. All single use syringes were single use only, this is an improvement from the previous audit, however this audit evidenced medication shortfalls around eye drops dating and out of date medication.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional</p>	FA	<p>All meals are prepared and cooked on site. There is a kitchen manager, two cooks and three kitchenhands employed. Food services staff have attended food safety and chemical safety training. The food control plan has been approved until May 2020. Cultural preferences and special diets are met. The cook receives a resident dietary profile for all residents and is notified of any dietary changes. Likes and dislikes are known and accommodated.</p>

<p>needs are met where this service is a component of service delivery.</p>		<p>Special diets are accommodated including, rice-based dishes, curries, and gluten free, vegetarian, and food allergies and modified food textures. Meals are served to rest home and hospital residents directly from the kitchen or transported in hot boxes.</p> <p>Fridge and freezer temperatures are taken and recorded daily. Perishable foods sighted in all the fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely. A maintenance and cleaning schedule is maintained.</p> <p>Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the meals provided. Alternatives are offered for dislikes.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition alters, a registered nurse initiates a review and if required, GP or nurse specialist consultation. Discussions with families confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for residents with wounds.</p> <p>The service had 18 wounds including four pressure injuries logged on the day of audit. All wound care plans reviewed had a documented assessment, a wound management plan and had been evaluated according to timeframes. There were four grade two pressure injuries, all facility acquired, all of which evidenced signs of healing.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring forms are used for weight, vital signs, and blood sugar levels, pain, challenging behaviour, food and fluid charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are</p>	FA	<p>The service employs an activities person who works Monday to Friday. She has been in the role for two and a half years.</p> <p>The programme is Monday to Friday and integrated to meet the physical and psychosocial well-being of the residents. The programme includes new activities when requested by residents. The programme is varied and includes culturally appropriate activities such as a Korean orchestra. Individual activities are provided in resident's rooms or wherever applicable.</p>

appropriate to their needs, age, culture, and the setting of the service.		<p>On the days of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly.</p> <p>The activity coordinator undertakes an assessment for each new resident and develops an activities resident profile on admission. Individual activity plans were stored in electronic resident files. The activities person contributes to the six-monthly resident review with the RN. The service receives feedback and suggestions for the programme through resident meetings and direct feedback from residents and families.</p> <p>The service has a van for transportation. Residents interviewed described van outings, musical entertainment and attendance at a variety of community events.</p> <p>Residents interviewed spoke very positively about the varied activities programme which they have input into.</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 for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN six monthly or earlier for any health changes for the long-term files reviewed. Written evaluations and six monthly interRAI assessments identified progress towards goals and care plans updated or re-written as required. The GP reviews the residents at least three-monthly.</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>	FA	<p>The building has a current building warrant of fitness that expires 15 December 2020. Daily maintenance requests are addressed. There is a preventative maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Hot water temperatures have been maintained between 43 and 45 degrees in resident areas, this is an improvement from the previous audit.</p> <p>The service is built onto a hill on three levels with a lift and stairs between floors. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade are provided.</p> <p>The caregivers and RNs stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections, based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If</p>

accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		there is an emergent issue, it is acted upon in a timely manner. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers. There were four restraints in use (three bed rails and one lap belt) and 14 residents using enablers at the time of audit. Staff receive training around restraint minimisation that includes annual competency assessments. Two files were reviewed (one with restraint and one with an enabler). Both had the risks associated with use assessed and reflected in the care plan, three monthly GP reviews, and monthly review through the quality assurance meeting.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	There are medication policies in place that give clear guidance for staff around medication processes and storage. On the day of audit not all eye drops had been dated and one medication was out of date.	On the day of audit, two eye drops were not dated on opening and one packet of intravenous midazolam was out of date in the upstairs medication room.	Ensure that eye drops are dated on opening and all medication is stored within date.  30 days

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

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

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

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

No data to display

End of the report.