

Kaylex Care Limited - Eastcare Residential Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Kaylex Care Limited	
Premises audited:	Eastcare Residential Home	
Services audited:	Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 26 January 2022	End date: 27 January 2022
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:	38	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Eastcare Residential Home provides rest home and dementia level care for up to 46 residents. The service is operated by Kaylex Care Limited and managed by a facility manager and a clinical manager. The most significant change since the previous 2020 audit is the appointment of a new facility manager in October 2021. There have been no changes to the scope and size of the service or the building.

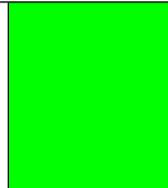
This recertification audit was conducted against the New Zealand Health and Disability Services Standards and the provider's contract with the Waikato District Health Board (WDHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, and a general practitioner. The company operations manager was on site for both days of the audit and was also interviewed.

The residents, their family members and a general practitioner interviewed expressed their satisfaction with the care and quality of services provided.

Three areas requiring improvement were identified during this audit. These relate to the extent of reporting that is provided to the general manager/governance, analysis of incidents and accidents including infections and surfaces in the kitchen.

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 provides care that reflects the Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code is promoted and shared with residents, family/whanau members and staff. Consumers and family/whanau advised that the service treats them with dignity and respect.

Residents are encouraged to maintain cultural customs and connections with their community.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

Communication needs are met.

A complaints register is maintained. When complaints have been received, these are investigated, and all information related to these is held on record. There was one complaint open at the time of this audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Current strategic, quality and risk management plans which include the scope, direction, goals, values and mission statement of the organisation are in place. A qualified and experienced manager is available and on site Monday to Friday. There is regular communication between the facility manager, operations manager and general manager.

Quality and risk management systems are well established. Service delivery was being regularly monitored. Adverse events were being reliably reported and investigated to determine cause and prevention. People impacted by an adverse event were notified. The operator understands their obligation to make essential notifications and actions this when required.

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Access to Eastcare Residential Home is efficiently managed with relevant information provided to the potential residents/family members. The clinical manager and the general practitioner (GP) assess residents on admission. The care plans demonstrated appropriate interventions and were individualised. Residents are reviewed regularly and referred to specialist services and to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents. All internal and external areas were clean, and the building and chattels are well maintained. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. All external areas are accessible and safe for residents' use.

Waste and hazardous substances are well-managed. Staff use protective equipment and clothing. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells.

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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Eastcare Residential Home has a philosophy and practice of no restraint. There were no restraint or enablers in use on the days of audit.

Policies and procedures meet the requirements, if a restraint is required, and staff education is ongoing.

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.

The infection prevention and control programme is managed by a trained infection control coordinator. It aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results shared with all staff. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	42	0	2	1	0	0
Criteria	0	90	0	2	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

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Residents receive services that meet the consumer rights legislation. The service has developed and implemented policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>The staff were observed communicating with residents in a respectful and courteous manner. On the days of the audit residents were observed being encouraged to be independent, options were provided, and privacy and dignity was maintained. This was confirmed in interviews conducted with residents and family/whānau.</p> <p>The interviewed staff understood the requirements of the Code. Training on the Code is included as part of the orientation process for all staff employed and in ongoing annual training, as was verified in staff training records sampled.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	FA	<p>The interviewed clinical manager and caregivers understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Informed consent is part of the admission process and general consent has been gained appropriately. Signed admission agreements and general consent forms were sighted in the clinical files reviewed. Resuscitation treatment plans and advance directives are also part of the admission process and were sighted in</p>

<p>give informed consent.</p>		<p>the reviewed residents' records as applicable. Staff were observed to gain consent for daily cares.</p> <p>The interviewed residents, family/ whānau and EPOAs for residents in the dementia units confirmed having signed the admission agreements and consent forms as required.</p> <p>Influenza and COVID-19 vaccination consent forms were sighted in residents' files sampled.</p> <p>Advance care plans were sighted where applicable.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Advocacy Services pamphlets are given to residents, family/ whanau and EPOAs on admission to the service. The residents' information booklet has information on Advocacy services and the Code.</p> <p>The clinical manager and facility manager stated that in the event of a complaint made or any time during service delivery, residents and their family/ whānau are offered an option of an independent advocate who will be available for support as required.</p> <p>Residents in the dementia units had support of EPOAs. Activated EPOAs were sighted in the sampled files for residents in the dementia units.</p> <p>The interviewed family/whanau, residents and EPOAS were aware of the Advocacy Service, how to access this and their right to have support persons. Interviewed staff understood the Advocacy policy and procedure.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service encourages visits from residents' family/whānau and friends. A number of visitors were observed visiting residents on the days of the audit. Visitors are required to follow the COVID-19 pandemic MOH guidelines when visiting the facility. During the level four COVID-19 pandemic visiting restrictions, contact with family was via phone calls and virtual meetings.</p> <p>Family/whānau and EPOAs for residents in the dementia units expressed satisfaction with staff attitude when they visited and stated they felt comfortable in their dealings with staff.</p> <p>Residents are assisted to maintain links with their family and the community by having organised external entertainers visiting the service, and residents can go out on social outings with family. This was observed on the days of the audit.</p>
<p>Standard 1.1.13: Complaints</p>	<p>FA</p>	<p>Records and staff and resident interviews showed complaints are managed according to policy and Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The</p>

<p>Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>complaints register recorded eight complaints received in 2021 and none to date in 2022. The documentation attached to these confirmed investigations occurred and that these were resolved to the satisfaction of the people involved.</p> <p>Family members interviewed said they knew about the complaints process and that they had no hesitation in raising concerns or lodging complaints.</p> <p>A complaint received by the Office of the Health and Disability Commissioner in April 2021 is still under investigation.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents, family/whānau, their chosen representative and/or their legal representative for residents in the dementia units are provided with an explanation of the consumer rights on admission by the admitting nurse. This was confirmed in interviews with residents and whanau/EPOA for residents in the dementia units.</p> <p>The Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) posters are prominently displayed on the notice board near the reception area. The Code posters were in English and Māori languages. Information on advocacy services, complaints, and feedback forms were available at the reception area. The complaints and suggestion box near was near the reception area and accessible to residents and family/whānau.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>All residents have individual rooms that provide personal privacy, physical, visual and auditory dignity for residents during care. On the days of the audit, privacy and dignity were observed to be provided as personal cares were being undertaken. The bathrooms had clear signage when in use. Interviewed residents reported that they were respected by staff during care delivery. Staff were observed respecting residents' personal areas and privacy by knocking on the doors before entry. Residents and family/whānau confirmed that services were provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Residents are allowed to bring limited personal belongings they can relate to. The personal belongings and property are recorded on admission and are labelled for easy identification. The residents reported that they receive back their clothes after laundering in a timely manner.</p> <p>Residents are supported to attend to community activities to meet their individual needs. The interviewed staff stated that an escort is provided as when needed to promote residents' independence. Residents who wished to make their own beds were supported to do so. The care plans included documentation related to the residents' abilities, and strategies to maximise independence. Residents stated that staff encourage and support them to maintain their</p>

		<p>independence wherever possible.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan. All staff have received education on abuse and neglect. The training is provided annually for all staff - records were sighted. Interviewed staff demonstrated awareness of abuse and neglect and actions to take if required.</p> <p>The interviewed GP, residents and family/whānau have not witnessed or observed any abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Residents who identify as Māori are supported to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into daily practice, as is the importance of whānau. The Māori Health plan in place is current and it focusses on Tapu and Noa as the fundamental concepts that underpin the four cornerstones of Māori health. Two staff who identify as Māori have assisted Eastcare Residential Home to develop the Māori Health care plan and guidelines.</p> <p>Guidance on tikanga best practice is available. Māori cultural advisory is provided through the nominated cultural officer, a staff member at the service and local DHB if required. The cultural officer is involved in the monthly activities meetings to ensure that appropriate activities are included for residents who identify as Māori.</p> <p>Residents who identify as Māori and their whānau reported that staff acknowledge and respect their individual cultural needs. Staff have received education on cultural awareness.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and their family/whānau representative of choice are consulted on their individual values and beliefs, including ethnic, cultural and spiritual values and beliefs, on admission assessment. Residents or residents' representative of choice or enduring power of attorney (EPOA) where appropriate provided this information during the admission process as confirmed in interviews. Interviewed residents and family/whānau confirmed that individual values and beliefs are respected.</p> <p>There are policies and procedures to guide staff in providing care in a culturally safe manner. The care plans reviewed included residents' individual preferences, required interventions and special needs.</p> <p>The satisfaction survey confirmed that individual needs were being met.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The service has current policies and procedures that outline the safeguards to protect residents from discrimination, coercion, harassment, sexual, financial or any other exploitation. Residents, family/whanau, including the EPOAs for residents in the dementia units and the GP stated that residents were free from any type of discrimination, harassment or exploitation and felt safe.</p> <p>The orientation process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. These are included in the employee handbook and are discussed with all staff during orientation period. The registered nurses ((RNs) have completed training on professional boundaries.</p> <p>Staff demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Eastcare Residential Home encourages and promotes good practice through evidence-based policies that are reviewed regularly and regular internal audits. The service works in collaboration with external specialist services and allied health professionals, for example, wound care specialist and mental health services for older persons where required. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff receive regular education that includes mandatory training topics. This was confirmed by the interviewed staff and staff training records reviewed. The training calendar for the year and education evaluation records were sighted. The RNs have access to external education through the local hospital board, though this was limited over the past year due to COVID-19 pandemic restrictions. Staff reported that they receive support from senior staff as required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Interviewed residents, family/whānau and EPOAs for residents in the dementia unit stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. The GP confirmed that meetings with family/whānau are arranged by the clinical manager if requested or when required.</p> <p>Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code.</p> <p>The clinical manager stated that during the admission process residents who do not have English</p>

		<p>as their first language are offered availability of interpreting services. Access to interpreter services is through the local district hospital board. Staff knew how to access interpreter services, although reported this was rarely required due to most residents able to speak English. Staff can provide interpretation as and when needed, or family/ whānau and EPOAs are used for those with communication difficulties. Written communication and verbal ques are some of the methods used for residents who had communication difficulties. Email communication records were sighted in the residents' files sampled.</p> <p>There is a family/ whanau room that is utilised for meetings as when required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>PA Moderate</p>	<p>The company (Kaylex Care Ltd) has an overarching strategic/business and risk plan for the two facilities it operates, and each facility has a unique annual business plan. This described a family centred approach as required for dementia services.</p> <p>Although there is frequent communication between the facility manager, operations manager and governance (the general manager) there is a requirement in criterion 1.2.1.1 for the facility manager to provide more detailed and comprehensive reports to the general manager. The current quality and risk plan for Eastcare Residential Home contains a set of new goals for 2022. Progress against these need to be included in reports to the general manager.</p> <p>A new facility manager (FM) was appointed in October 2021. This person who is a registered nurse (RN) with a current practising certificate, has 27 years' experience managing and nursing in age care facilities. They have been fully supported and oriented to the role by the operations manager who has worked for the company as an RN and FM for 12 years. The onsite fulltime clinical manager (CM) oversees clinical matters. The clinical manager has been in the role for 18 months and is sufficiently experienced as an RN working in aged care environments. Both the FM and CM are experienced in the care of people with dementia and are attending at least eight hours of professional development related to their roles, each year.</p> <p>At the time of this audit, there were 38 residents occupying the available maximum of 46 beds under the DHB age related residential care contract (ARRC). There are 15 rooms allocated for rest home care and 31 rooms for dementia level care spread across two units. One unit has a maximum 15 beds and the other has 16 beds. One bedroom in Tui wing was decommissioned in 2019. The organisation also has DHB agreements for short stay/respice service and day attendance for people diagnosed with dementia. There were no respice residents and the day programme has not operated since March 2020 and the onset of the Covid pandemic.</p> <p>Fourteen of the residents on site were assessed as requiring rest home level care, one was receiving hospital level care (under current dispensation) and 23 people, across the two dementia</p>

		wings, required secure care. All are long term placements. One resident was under the age of 65 years and funded under the long term support-chronic health care (LTS-CHC) scheme.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the facility manager is absent, their role is substituted by the RN, with support from the operations manager who manages the other aged care facility in Hawke's Bay. This person was managing the facility during the transition of facility managers and is informed about the residents and their care needs. A senior RN from the Hawke's Bay facility would also be seconded to back fill the clinical manager's role if needed, otherwise the FM who is also an RN, covers the clinical managers' role during any planned or unplanned absences.</p> <p>Staff and the families and residents interviewed said services were managed to their satisfaction.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>There is an established quality and risk management system which includes policies and procedures. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. These are controlled and updated two yearly or as required to meet known safe practice.</p> <p>The quality/risk system includes collecting data from incidents and complaints, surveillance of infections, the results of internal audits and monitoring the effect of actions to remedy any deficits. Regular resident and family satisfaction surveys are conducted. Outcomes from the 2021 and responses received so far from the 2022 satisfaction surveys reveal good to high satisfaction with the services being provided.</p> <p>Residents said that they were consulted about any proposed changes in the service and were kept informed at their monthly meetings.</p> <p>The number and type of incidents/accidents and infections are collated by the RN every month. This requires an improvement (Refer criterion 1.2.3.6).</p> <p>Monthly statistical and narrative data was displayed in the staff room, and any adverse events are communicated at shift handover. These events are further discussed at monthly staff meetings. Documented evidence of corrective actions was sighted on incident/accident reports, on the internal audit tools where a deficit or gap is identified, in the hazards register, and in complaints documentation. The service develops quality improvement plans when service deficiencies or</p>

		<p>opportunities to improve are identified.</p> <p>The organisation's annual quality plan, business plan and associated emergency plans, document actual and potential risk to the business, service delivery, staff and/or visitors' health and safety. Health and safety policies comply with the current legislation, and the manager who is the health and safety officer has completed the stage one health and safety representative training (unit standard 29315) by Worksafe NZ.</p> <p>Environmental risks were observed to be communicated to visitors, staff and residents as required, through notices, or verbally, depending on the nature of the risk. For example, vaccine passport checks occur before entry to the home and requests to sanitise hands and don masks were happening for every visitor and staff. Review of staff meeting minutes showed that quality matters, and health and safety is presented for discussion at general staff monthly meetings. The health and safety committee meets each month to monitor and implement actions to meet health and safety requirements. There have been no injuries which required notification to Worksafe NZ since the previous audit.</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>There were well known and established processes for the reporting, recording, investigation and review of all incidents and accidents. Review of onsite documents and interviews with staff and management confirmed that incidents were discussed at staff meetings. There is an improvement required related to collation and analysis of adverse event data in criterion 1.2.3.6.</p> <p>Interviews and review of incident data on the days of audit confirmed that incidents are communicated at shift handover, and further discussed at monthly staff meetings. Each resident's care record contained a summary of incidents which facilitates a ready review of risks.</p> <p>The manager is responsible for essential notifications and reporting and understood the statutory and regulatory obligations. Notifications about the appointment of the new facility manger and an unexpected death in late December 2021 had been reported to the Ministry of Health as required under section 31 of the Health and Disability (safety) Act.</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</p>	FA	<p>Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Two new staff reported</p>

legislation.		<p>that the orientation process prepared them well for their role.</p> <p>Continuing education is planned on an annual basis, including mandatory training which included: emergency procedures; health and safety; managing challenging behaviours; communication; and infection control. Specific training related to Covid precautions and management, such as mask use, donning and doffing protective equipment, had been delivered to all staff.</p> <p>All care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Of the 24 care staff, four have completed level 4 of the national certificated in health and wellness, three have completed level 3, two are at level two and three new staff are enrolled to begin training.</p> <p>All staff working in the dementia care areas have either completed or are enrolled to complete the required dementia care unit standards 23920-2392.</p> <p>Both RNs (the FM and the CM) are trained and maintaining their competencies with interRAI assessments.</p> <p>The sample of staff records reviewed showed attendance at ongoing training and completion of annual performance appraisals. All the care staff on duty have a current first aid certificate as does the CM and FM.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7) is documented and implemented. The facility adjusts staffing levels to meet the changing needs of residents. Care staff said there were enough staff on each shift to complete the tasks required.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with absent staff replaced by existing staff doing extra hours. There were five caregivers allocated across the facility for each morning and afternoon shift and two at night. The CM/RN and the FM/RN are onsite Monday to Friday between 8.30 and 5 pm.</p> <p>There are sufficient staff hours allocated for meal preparation and service, cleaning and laundry seven days a week, and a fulltime employed activities person. Recruitment for a maintenance person is underway. The maintenance person from the other facility is on site two days a week in the interim.</p>
Standard 1.2.9: Consumer Information	FA	<p>The residents' files are paper based and all staff document in progress notes. The residents' files are colour coded for each unit. The RNs complete care plans electronically, and copies are printed</p>

<p>Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>and put in the residents' paper file. These documents were sighted in the residents' clinical records sampled.</p> <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This included interRAI assessment information entered into the Momentum electronic database and reports printed and stored in the residents' files.</p> <p>Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Medication records are electronic in the electronic medication management system in use.</p> <p>Staff have individual passwords to access the electronic systems.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. The clinical manager is responsible for archiving clinical records. Residents' information is held for the required period before being destroyed.</p> <p>No personal or private resident information was on public display during the audit. The residents' files were kept in locked nurses' station. A shredder is used for destruction of unwanted confidential information.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated by the facility manager (FM) and the clinical manager (CM) in a competent, timely and respectful manner. There is an admission policy and procedure to guide staff. Access processes and entry criteria, assessment and entry screening processes are documented in the service's information booklet. The processes are explained to prospective residents, their family/whānau of choice or EPOAs where appropriate, local communities and referral agencies when needed. Services provided are clearly stated on the services website and information booklet. Prospective residents and/or their family/whānau are encouraged to visit the service prior to admission and are provided with written information about the service and the admission process. A tour of the facility is conducted at that time if desired.</p> <p>The FM and CM are responsible for the admission process. The sampled files confirmed that residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. NASC assessment forms with the documented level of care were sighted in the residents' files sampled.</p> <p>Family/whānau, EPOAs and residents interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Residents in the secure dementia units were admitted with the consent of their EPOAs. Signed admission</p>

		agreements were sighted in the residents' records reviewed.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The residents' discharge or transfer is planned and coordinated by the CM and FM. An escort is provided as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. Open communication between all services, the resident and the family/whanau were evidenced in the transfer records sighted. The transfer records for a resident that was transferred to acute services demonstrated that appropriate information was provided for the ongoing management of the resident. All referrals were documented in the progress notes. Family of the resident reported being kept well informed during the transfer of their relative.</p> <p>The CM stated that if the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident, whānau/family or EPOA. Documentation to evidence this was sighted for a resident who was transferred to another facility. The access agreement has a clause related to when a resident's placement can be terminated, and this is explained to the residents and family/ whanau on admission.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Eastcare Residential Home has a safe electronic medication management system in place that was observed on the days of the audit. The medication management policy is current and identified all aspects of medicine management in line with safe practice guidelines and current legislative requirements. Staff who administer medication had current medication administration competencies. A list of medication administration competent caregivers was maintained and was accessible to all staff.</p> <p>The caregivers observed administering medicines demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Medicines were stored safely in the locked cupboards and medicine trolley in the medication room. Staff have individual passwords to access the electronic medicine records. The medicine fridge temperature was monitored, and records were maintained.</p> <p>Medications are supplied to the service in a pre-packaged format from a contracted pharmacy. The CM completes the medication reconciliation upon residents' readmission from an acute service and when medication is received from the pharmacy. Clinical pharmacist input is provided on request. Unwanted medicines are returned to the pharmacy in a timely manner. There were no expired medicines in stock.</p>

		<p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. A current staff signature register was sighted.</p> <p>The CM reported that any medication errors are documented, and appropriate investigations will be completed. There were no medication errors recorded within the past year.</p> <p>Three-monthly medication reviews were consistently completed by the GP, as evidenced on electronic medicine charts reviewed. Dates were recorded on the commencement and discontinuation of medicines. Evaluation of pro re nata (PRN) medicines administered were completed consistently.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner when required. Interviewed staff demonstrated awareness of the medication self-administration process.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>The food service is provided onsite by three cooks who have completed basic food safety training. Food, fluid and nutritional needs of the residents are provided in line with recognised nutritional guidelines for older people. There is a summer and winter menu that rotates on a four-weekly cycle. The menu was reviewed by a qualified dietitian on 10 November 2021. Recommendations made at that time have been implemented. The service operates with an approved and current food safety plan and registration issued by the Ministry of Primary Industries expiring on 27 June 2022. Regular external food verification audits were completed.</p> <p>Residents' nutritional needs were identified on admission and a dietary profile developed. Special dietary requirements, including likes, dislikes and allergies were identified and accommodated in the meal plan. Nutritional supplements were provided for residents with loss of weight issues. Residents in the secure unit always have access to food and fluids to meet their nutritional needs.</p> <p>Special equipment, to meet residents' nutritional needs, was available. The meals are served in dining rooms in each unit and residents who do not want to go to the dining rooms can have meals served in their room as desired. The kitchen staff coordinates special celebration with the activities staff.</p> <p>The residents and family/whānau reported satisfaction with the food service, and this was verified in the satisfaction surveys sighted. Residents can provide feedback on the meals in monthly residents' meetings or as when needed. Regular kitchen staff and management meetings are held. Meeting minutes were sighted. Alternate food options are provided per request. On the day of the audit residents were given enough time to eat their meals in an unhurried fashion.</p>

		Some bench surfaces and cupboards in the kitchen were degraded and poses a potential risk of infection.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The CM manager stated that a referral can be declined if the prospective resident does not meet the entry criteria or there is no vacancy. The local NASC is advised to ensure the prospective resident and family/whānau are supported to find an appropriate care alternative. The prospective resident and family/ whānau will be advised of the reason for the decline and will be informed of other alternative services available or referred to NASC as appropriate.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Nursing assessments were completed on admission using the organisation's initial assessment form. The assessed areas included pain, falls risk, pressure area risk, nutrition, continence, personal cares and behaviour, as a means to identify any deficits and to inform care planning within 24 hours of admission. Behaviour assessments including triggers and ways to manage the behaviours were completed for residents in the dementia units.</p> <p>InterRAI assessments were completed within three weeks of admission, routinely six-monthly and when there was a significant change in the resident's condition. The sample of care plans reviewed had an integrated range of resident-related information. All residents had current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions.</p> <p>Residents, families/whānau and EPOAs for residents in the dementia units confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Behaviour management care plans were completed for residents in the dementia units.</p> <p>Service integration was evidenced in the care plans with progress notes, activities assessments, medical and allied health professionals' notations clearly written, informative and relevant. Changes in care required was documented and verbally passed on to relevant staff at the start of each shift and during the daily head of department meetings.</p> <p>Residents, family/whānau and EPOAs confirmed participation in the development and ongoing</p>

		evaluation of care plans.
<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>The sampled residents' care plans, observations and interviews verified that care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision.</p> <p>Significant changes were reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted.</p> <p>Monthly nursing observations monitoring was completed for all residents, and records were maintained. Care staff confirmed that care was provided as outlined in the care plans.</p> <p>A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by an activities coordinator (AC) under the direction of a diversional therapist who was on leave on the days of the audit. The AC is in the process of completing NZQA approved dementia training.</p> <p>Residents' activity needs are assessed as part of the admission process with input from the resident and family/whānau to ascertain residents' needs, interests, abilities, and social requirements. The AC completes the 24-hour activity plans for the residents in the dementia unit while the CM and the FM completes activities care plans as part of the long-term care plans for all residents with input from the AC. The activities programme is regularly reviewed to help formulate an activities programme that is meaningful to the residents through monthly residents' meetings and satisfaction surveys.</p> <p>The activities participation register was completed daily as evidenced in the records reviewed. The residents' activity needs were evaluated when there was a significant change in participation and as part of the formal six-monthly interRAI assessment and care plan review.</p> <p>A monthly calendar was posted on the notice boards around the service. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents were observed participating in a variety of activities on the days of the audit. Activities on the programme included walking groups, newspaper reading, gardening, weekly church services, puzzles, exercises, music, external entertainment, movies, and birthday celebrations. The interviewed residents confirmed that they find the programme satisfactory.</p>

		<p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living with dementia. The AC stated that activities are adapted to meet the residents' needs and mood. The residents were observed participating actively in activities on the days of the audit and were given an opportunity and choice to participate or not. The residents were observed walking freely in and out of the secure gardens. The staff were observed communicating with residents in a respectful manner during the activity sessions observed on the days of the audit. Activities are offered at times when residents are most physically active and/or restless. This includes short walks in the secure garden, colouring, art and craft.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes by the caregivers. The caregivers reported that any changes noted are reported to the CM. This was confirmed in the handover observed and in residents' records reviewed.</p> <p>Routine care plan evaluations were completed every six months following the six-monthly interRAI reassessment, or as residents' needs change. Where progress was different from expected, changes were made to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated for wounds, skin, and urinary tract infections. Multi-disciplinary review meetings were conducted six-monthly with the family/whānau, EPOA for residents in the dementia units and the nursing team. Residents and family/whānau interviewed confirmed being involved in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP, CM or FM sends a referral to seek specialist input. Evidence of EPOA involvement for referrals for residents in the dementia unit was sighted in residents' records sampled. Copies of referrals sighted included referrals to the mental health team, radiology, and dietitian. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Any acute/urgent referrals are attended to immediately, such as sending the resident to the public hospital in an ambulance if the circumstances dictate. Urgent referral records were sighted in the residents' files reviewed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p>	FA	<p>All staff who handle chemicals have completed safe chemical handling training. An external company is contracted to supply and manage chemicals and cleaning products and provide staff with product information. Material safety data sheets were available where cleaning and laundry</p>

<p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Appropriate signage is displayed where necessary.</p> <p>There are sufficient supplies and availability of protective clothing and equipment, and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 01 December 2022) is publicly displayed.</p> <p>There have been no changes to the environment since the previous audit in 2020. The building layout, design features and furniture in both dementia units is safe and suited for the needs of confused older people. There are pictorial signs on the toilets and bathrooms and each resident's bedroom is identified with name and images that the individual relates to.</p> <p>Electrical items are regularly tested and tagged by the maintenance person who is certificated to do this. Visual inspection, records reviewed and interviews with maintenance staff and staff confirmed that planned and reactive repairs and maintenance is ongoing. The building, chattels and equipment are in good repair. Medical equipment (for example, blood pressure monitors, weigh scales, and the two hoists) are being serviced and recalibrated annually. External areas are being maintained by gardening contractors. These were observed to be safe.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are sufficient numbers of accessible bathroom and toilet facilities throughout the facility. All toilet and shower facilities are shared, with a total of seven bathrooms and eleven toilets allocated for residents. All bathrooms and toilets have functional locking systems for privacy. A staff and a visitors' toilet are designated.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. All ablution areas were in good condition.</p> <p>The testing and monitoring of hot water temperatures occurs monthly. Records showed that temperatures are within a safe range.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas</p>	<p>FA</p>	<p>All bedrooms have a single occupant. Attention is paid to the layout of furniture in bedrooms to allow residents and staff to move around safely. There was evidence that residents had their own furniture and possessions. Sufficient space is available to store mobility aids and wheelchairs.</p>

appropriate to the consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Each of the three wings has its own lounge and dining room and these are located within easy walking distance from the resident's bedrooms.</p> <p>There are quiet areas for families to visit their relatives.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Designated cleaning and laundry staff are on site seven days a week. These staff have achieved qualifications in safe handling of chemicals and are provided with ongoing health and safety education as confirmed in interview with staff and review of their personnel records.</p> <p>Staff follow established routines for cleaning and all areas are maintained as hygienic. Site inspection revealed no concerns with daily cleaning. Chemicals are decanted into clearly labelled containers.</p> <p>The laundry is being managed on site according to known protocols for dirty/clean flow and the handling of soiled linen. There have been no concerns expressed from staff, resident or relatives about cleaning or laundry services since the previous audit. Cleaning and laundry processes are routinely monitored for effectiveness via the internal audit programme, from the external cleaning product supplier and through resident/family surveys and feedback.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The fire evacuation scheme was approved by the New Zealand Fire Service in November 2010 after changes to the building footprint. The most recent fire drill occurred on 20 January 2022 and records showed this occurs every six months. Specific procedures for evacuating people with dementia are documented and known. Staff interviews confirmed their understanding of evacuation procedures in the two dementia wings. The recent trial evacuation did not identify any issues of concern in moving residents to safety and was completed within five minutes. The orientation programme includes fire and security training.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, communication devices (a walkie talkie) and gas BBQ's were sighted and meet the requirements for the maximum number of residents. Sufficient potable water (1600 litres) is stored</p>

		<p>in the building to meet the needs of 47 residents and staff for up to 10 days which exceeds the Ministry of Civil Defence and Emergency Management recommendations for the region. Adequate supplies for use in a pandemic are stored on site.</p> <p>Apart from a backup battery for lighting (which is regularly tested) there are no generators on site for power outages. The protocol is to hire one.</p> <p>Call bells alert staff to residents requiring assistance. Staff were observed to respond within reasonable timeframes to these.</p> <p>Appropriate security arrangements are in place. There are security stays on all windows. The only access to the building is via the main entrance, and this door is locked at a 5pm each day.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Residents' bedrooms and communal areas have sufficiently sized windows and opening doors for ventilation. Each communal area has at least one heat pump which provides warmth or cooling, and electric panel heaters are in each bedroom. Family and residents interviewed said the home was kept at a comfortable temperature in all seasons.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external specialists. The infection control programme is reviewed annually and last reviewed on 14 January 2022.</p> <p>The CM is the designated infection control coordinator (ICC), whose role and responsibilities are defined in their job description. The ICC is supported by the FM. Infection control matters, including surveillance results, are reported monthly to all staff, and tabled at the management and staff meetings. The IPC committee includes the CM, FM manager, a senior caregiver, a cook and household representatives.</p> <p>There is signage at the main entrance to the facility requesting anyone who is or has been unwell with flu like symptoms in the past 48 hours, not to enter the facility. The interviewed staff understood their responsibilities on how long they must stay away from work if they have been unwell. Covid-19 contact tracing information was maintained and symptoms check was completed for all visitors at the reception area.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICC has been in this role for one and a half years and has appropriate skills and knowledge for the role. They have attended relevant infection prevention and control education, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The ICC has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. Adequate resources were sighted on the days of the audit. Updated information on COVID-19, including vaccination information was available and easily accessible to staff and residents. All eligible residents have received the COVID-19 vaccination. Vaccination consent forms were sighted in the residents' files sampled for review.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed in January 2021 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitisers were readily available around the facility. The interviewed staff demonstrated knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. There was evidence that additional staff education has been provided in response to the COVID-19 pandemic.</p> <p>Education with residents is on a one-to-one basis for any infections and in groups during residents' meetings. This included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. COVID-19 pandemic infection prevention and control education was provided to residents in residents' meetings and emails were sent to family/whanau. This was verified in residents' meeting minutes, short-term care plans sighted and in interviews with family/whanau.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, multi-resistant organisms, skin, ear nose and throat and the upper and lower respiratory tract. Infection reports are completed for all infections and the ICC reviews all reported infections. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. This was confirmed in the handover observed and in staff interviews.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Regular IPC audits were completed, and corrective actions were implemented as required. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. There have been no infection outbreaks reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service had no restraint or enablers in use at the time of this audit and has always taken the approach of using alternatives to restraint. The only restraint interventions have been one off emergency restraint events. The last events recorded were in 2015. This is made clear in the organisation's restraint minimisation and safe practice policies and associated procedures. The reviewed policy meets the required Health and Disability Services Standards and clearly describes emergency restraint authorisations and the requirements to meet this standard if restraint is required. The definition of an enabler is congruent with the definition in NZS 8134.0.</p> <p>Sensor mats are in position to alert staff when residents who pose a falls risk are ambulatory. In-service education focuses on alternatives to restraint and managing challenging behaviour. Interviews with the staff and review of individual training records confirmed that education on maintaining a restraint free environment and safe practice occurs at orientation and at least every year after that.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	<p>PA</p> <p>Moderate</p>	<p>Currently the reporting up to executive level/governance is occurring via weekly zoom meetings between the FM, operations manager and the general manager. Occupancy reports are submitted each month but there was no other written record of operational matters/service delivery or progress reporting against quality goals.</p>	<p>There was no auditable record of reports related to operational and service delivery matters such as quality and risk, staffing or progress toward meeting quality goals. Without this governance cannot ensure services are planned, coordinated and suitable for residents.</p>	<p>Provide evidence that governance (GM) is kept fully informed about all aspects of service delivery at Eastcare including emerging risks, and improvements.</p>

				60 days
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>The RN collates a monthly summary of incidents with a brief narration of events which is presented to staff at their meetings. Documents related to these are displayed in the staff room. The graphs produced by the software does not provide comparisons and are too small to easily interpret. This was rectified on the days of audit.</p> <p>The RNs monthly narration lacks detail, specifically unwanted patterns for individual residents (for example, increased frequency of unwanted behaviour) and no identification of upward (or downward) trends in each category reported. The data has not been compared across various timeframes to identify unwanted trends in, for example, falls, skin tears, infections, nor is there any external benchmarking.</p> <p>Although staff are taking actions to prevent recurrence of incidents and manage potential risks associated with this, the lack of in depth analysis limits opportunities for identifying service shortfalls and identifying where interventions have halted unwanted trends.</p>	There is insufficient analysis or comparison of incident/accident data to assist in identifying trends	<p>Implement an effective system for analysing and reporting trends in adverse events.</p> <p>90 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>The main cook is responsible for food procurement through approved food suppliers. A stock rotation system is in place. There are adequate hand washing facilities in the kitchen. The kitchen staff were observed wearing appropriate personal protective equipment during meal preparation. Appropriate documentation was completed when food deliveries were received, and records were maintained. The kitchen and pantry were clean. Completed cleaning schedules were sighted. Food temperatures were monitored appropriately and recorded as part of the food control plan. Food, fridge, and freezer temperatures were monitored, and records maintained. Left-over food was covered and dated. Food in the pantry were within use by dates. Some kitchen cupboards and benches were worn out and this poses a potential risk for infection.</p>	The surfaces in the kitchen (cupboards and benches) are degraded and pose a risk of contamination.	<p>Ensure all kitchen surfaces are intact.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.