Lexall Limited - Lexall Care

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

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: 16 April 2018 End date: 17 April 2018

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: 49

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

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 49 residents. The residents, relatives and general practitioner commented positively on the care and services provided.

This certification audit was conducted against the relevant 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 resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

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 2000.

Improvements are required around; corrective action plans and follow-up, documentation of orientation for new staff, water temperatures and use of single use items.

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 facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are being implemented and complaints and concerns are managed and documented. 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.		Some standards applicable to this service partially attained and of low risk.

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.

There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The activities staff provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

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

Safe and appropriate environment

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

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. 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. Resident bedrooms are personalised. All bedrooms have ensuite toilets or full ensuites. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	46	0	3	1	0	0
Criteria	0	97	0	3	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with ten care staff (four caregivers, five registered nurses (RN) including the charge nurse and one activities coordinator), confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Five residents (three rest home and two hospital level) and six relatives (three rest home and three hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent processes are discussed with residents and families on admission. Written general consents were included in the admission process as sighted in seven resident's files reviewed (five hospital including one under the long-term chronic condition contract and one interim care contract) and two rest home. Consent forms are signed for any specific procedures. Caregivers interviewed confirmed consent is obtained when assisting with care. Advance directives sampled identified the resident resuscitation status and/or signed by the resident (if appropriate) and the general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Copies of enduring power of attorney (EPOA) were seen in the resident files as appropriate.

		Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Admission agreements were sighted for the long-term residents.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility, including activities of daily living, for example, shopping and attending cafes and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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 were aware of the complaints process and to whom they should direct complaints. A complaints register has been maintained. There have been three complaints made in 2017 and one complaint received in 2018 year-to-date. There was documented evidence of response, follow-up and resolution to the complaints reviewed. Residents and family members advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code. Quarterly resident meetings provide the opportunity to raise concerns. An annual residents/relatives' satisfaction survey is completed.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff interviewed could describe the procedures for maintaining confidentiality of resident records, residents' privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	Lexall Care has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit there were two residents who identified as Māori. A review of one of the resident's files identified involvements in specific Māori community events as requested by the resident. Māori consultation is available through a local Māori Kaumātua as required. Staff interviewed could describe how they can ensure they meet the cultural needs of Māori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs or values are further discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities, and staff sign a copy on employment. The quality assurance meetings occur monthly and include discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the clinical manager, charge nurse, RNs and caregivers confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. The clinical manager is responsible for coordinating the internal audit programme. A variety of staff meetings are conducted. Residents and relatives interviewed spoke very positively about the care and support

		provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the clinical manager and charge nurse. Care staff complete competencies relevant to their practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were welcomed on entry and were given time and explanation about services and procedures. Family members interviewed also stated they are informed of changes in the health status of residents and incidents/accidents and fifteen incident forms reviewed confirmed this. Resident/relative meetings are held quarterly. The clinical manager and the charge nurse have an open-door policy. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	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 49 residents. Nineteen residents were at rest home level of care and 30 were at hospital level. This included three long-term support chronic health conditions (LTS-CHC) (one rest home and two hospital) and two DHB funded interim care (hospital). Five beds are dedicated as rest home only and the remaining 52 beds are dual-purpose. 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). A 2018 business/strategic and management plan is being implemented. The clinical manager reports that she meets with the general manager (owner) regularly and that meetings include reviewing the strategic goals. Quality goals are also documented for the service. These goals link to the business/strategic and management plan and are regularly reviewed in staff meetings. A quality assurance annual report was completed for 2017 to review the actions in place to achieve the quality goals. The clinical manager has maintained a minimum of eight hours relating to managing an aged care service.

Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During a temporary absence, the administration/finance manager and charge nurse cover the clinical manager's role. The general manager provides oversight and support.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	A quality and risk management programme is documented. 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 (if any), and infections. This data is collated, trended and analysed and is regularly communicated to staff at the quality assurance and staff meetings. Required actions and resolutions from facility meetings are documented. Minutes of these meetings are made available to all staff. A resident/family satisfaction survey was last completed in July 2017. However, there was no documented corrective action plan in place to follow-up on identified areas of improvement. There are quarterly residents' meetings conducted and families are invited to attend. Internal audits are completed as documented in the audit schedule. However, corrective actions are not consistently followed up and completed when internal audit findings are identified. 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. Health and safety policies have recently been reviewed (February 2018). Hazard identification forms and a hazard register reflect the regular monitoring of hazard controls. There is an up-to-date hazard register in place that was last reviewed in February 2018. 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.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their	FA	Individual reports are completed for each incident/accident with immediate action noted including any follow-up action(s) required. Incident/accident data is linked to the facilities quality and risk management programme. Fifteen accident/incident forms were reviewed for April 2018. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observations have been undertaken if there is a suspected head injury. The clinical manager is aware of the responsibility to notify relevant authorities in relation to essential notifications. There

family/whānau of choice in an open manner.		have been two section 31 notifications made since the last audit. One for a stage three pressure injury in April 2018 and one for a resident death in April 2018.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Human resources policies address recruitment, orientation and staff training and development. Nine staff files selected for review (one clinical manager, one charge nurse, two RNs, three caregivers, one cook and one activities coordinator) included evidence of the recruitment process including police vetting, signed employment contracts, reference checks and annual performance appraisals. Missing, was evidence of completed orientation programmes and checklists. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Staff interviewed stated that new staff are adequately orientated to the service. There is an annual education and training schedule for 2018 that is being implemented. Education and training for the RNs are supported by the DHB. There are 10 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.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	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. In wing one, two and three there are 31 residents in total (15 rest home and 16 hospital level). There is one RN on duty on the morning and afternoon shifts, and on the night shift. They are supported by three caregivers on the morning and afternoon shifts and two caregivers on the night shift. In wings four and five there are 18 residents in total (four rest home and 14 hospital level). There is one RN on duty on the morning and afternoon shifts. The RN from wing one, two and three covers the night shift. They are supported by three caregivers on the morning and afternoon shifts and one caregiver on the night shift. 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 report there are sufficient staff numbers.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office. Care plans and notes were legible and where necessary signed (and dated) by a RN. Entries are legible, dated and signed by the relevant caregiver or RN including designation. Individual resident files demonstrate service integration. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services for rest home and hospital level care, are provided for families and residents prior to admission or on entry to the service.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exits or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff that administer medications (RNs and occasionally some caregivers) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the paper based medication chart. All medications are stored safely in the two medication rooms (one upstairs and one downstairs). The medication fridges are maintained within the acceptable temperature range. All eye drops and ointments sited were dated on opening. There were no residents self-medicating on the day of audit. Standing orders are in use, all had been reviewed and signed for 2018. Sixteen 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. The use of single-use syringes was not appropriate.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	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 service is in the process of submitting their food control plan. 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. 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. 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. 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.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools. Risk assessments are completed six-monthly with the interRAI assessment or earlier due to health changes. Following an earlier action plan, interRAI assessments reviewed are now completed within 21 days of admission and six-monthly thereafter with all resident files reviewed having an up-to-date interRAI. Resident needs and supports were identified through available information such as discharge summaries, medical notes and in consultation with significant others and included in the long-term care plans.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident care plans reviewed were paper based, resident focused and individualised. Support needs as assessed, were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and were sighted in resident files, for example, pain, infections and wounds, and have either been resolved or if ongoing, transferred to the long-term care plan. Long-term care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. The resident on the long-term chronic condition contract had interventions documented for oxygen use and this was charted in the medication chart. The non-weight bearing, interim care, resident's care plan included all care needs and physiotherapy. Additional equipment had been brought in for the resident, who praised the service very highly. One resident who was on the palliative pathway had comprehensive care plan interventions and was observed to receive a high level of care in association with family. There was evidence of allied healthcare professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. Discussions with families confirmed they are notified promptly of any changes to their relative's health. 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. The service had 47 wounds including three pressure injuries logged on the day of audit. One resident, who had been a frequent faller and was on the palliative care pathway at the time of audit, had 20 wounds and the service had documented a separate wound care for each wound. All fifteen wound care plans reviewed had a documented assessment, a wound management plan and had been evaluated according to timeframes. There were two grade two pressure injuries, both hospital, one facility acquired, and one non-facility acquired. One grade three pressure injury was facility acquired. 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.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service employs an activities person who works Monday to Friday. She has been in the role for six months and is supported by an activity assistant who works in a neighbouring facility. 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; is varied, and includes culturally appropriate activities such as a Korean orchestra. There are regular outings into the community. The service has a van for regular outings. One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated. An activities resident profile is completed on admission. Individual activity plans were sited in long-term 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. Residents interviewed spoke very positively about the varied activities programme which they have input into.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	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.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet	FA	Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.

consumer choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training, provided by the chemical supplier.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	The building has a current building warrant of fitness that expires 15 December 2018. Two full-time maintenance staff undertake preventative and reactive maintenance. 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 not always been below 45 degrees in resident areas. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available 24-hours. 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 is provided. The caregivers and RNs stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All resident rooms have either an ensuite toilet or a full ensuite. There are sufficient communal showers. Hand basins, toilets and shower facilities are of an appropriate design to meet the needs of the residents. The communal toilets and showers have privacy locks. Residents interviewed confirmed care staff respect the resident's privacy when attending to their personal cares.
Standard 1.4.4: Personal Space/Bed	FA	All rooms are spacious. There is adequate room to safely manoeuvre mobility aids or hoists. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced

Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		personalised rooms which included the residents own furnishing and adornments.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The top floor has a main lounge and dining area, an activities room and a café for all residents, staff and families. The middle floor has a lounge and dining area and a satellite kitchen. The lower floor has a lounge and dining area and a satellite kitchen. There are seating alcoves appropriately placed within the facility. All communal areas are accessible to residents. Caregivers assist to transfer residents to communal areas for dining and activities as required.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated cleaning staff on duty seven days a week. Personal laundry is completed on-site, and linen is sent off-site to a commercial laundry. The laundry and cleaning staff have completed chemical safety training and laundry processes. The laundry has an entry and exit door. There is appropriate personal protective-wear readily available. The cleaner's trolleys are stored in a locked area when not in use. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food and supplies (torches, radio and batteries), emergency power and barbeque. A generator is able to be hired if required. There is an approved fire evacuation scheme in place and there are six monthly fire drills. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty. Resident's rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated, light up on corridor lights that are visible from all areas in the facility. Security policies and procedures are documented and implemented by staff. The buildings are secure at night with after-hour's doorbell access and there is security lighting.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature. Resident room temperatures are monitored through a central computer system. The residents and family interviewed confirmed temperatures are comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system. The clinical manager, a registered nurse, is the designated infection control coordinator. The infection control team are part of the quality assurance committee that meet monthly; this committee consists of the clinical manager, charge nurse, caregiver manager and receptionist. The charge nurse oversees the day-to-day IC processes and practice within the facility, she follows up the infection reports and writes the monthly IC report to be presented at the QA meeting. Internal audits have been conducted and include hand hygiene and infection control practices. The infection control programme has been reviewed annually.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	A registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse has external support from the IC nurse specialist at the DHB and gerontologist nurse specialist. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and	FA	The service uses infection control policies and procedures developed by an external consultant. The policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff.

procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator is supported by the gerontological nurse specialist from the DHB. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	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 there is an emergent issue, it is acted upon in a timely manner. One outbreak of diarrhoea and vomiting during February 2018 was effectively managed. Notification was made to public health.
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 two residents requiring the use of three restraints (two bed rails and one lap belt) and six residents using enablers at the time of audit. Staff receive training around restraint minimisation that includes annual competency assessments.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (charge nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.

providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Two hospital level residents where restraint was in use (two bed rails and one lap belt) and three hospital level residents using enabler (bedrails), were selected for review and contained completed assessments. The completed assessments considered those listed in 2.2.2.1 (a) - (h). The restraint coordinator in partnership with the RNs, GP, resident and their family/whānau, undertakes assessments. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality and staff meetings. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Internal restraint audits measure staff compliance in following restraint procedures. Reviews are completed three monthly or sooner if a need is identified by the restraint coordinator. Any adverse outcomes are reported at the monthly quality assurance meetings.

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)
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	The internal audit process is required to include corrective action plans when results are less than acceptable. There were a sample of internal audits completed that identified findings without associated corrective action plans. The resident/relative survey completed 2017 did not have any implemented corrective actions documented from the feedback received.	i) Ten of sixteen internal audits reviewed that required corrective actions, did not have documented evidence of being followed up and signed off as completed. ii) There was no documented corrective action plan in place to follow-up on identified areas of improvement from the resident/relative satisfaction survey completed in 2017.	Ensure that corrective action plans are documented where needed and these are followed up and signed off as completed.

				90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Recruitment policy and procedures describes the appointment process. Nine staff files selected for review included evidence of the recruitment process including police vetting, signed employment contracts, reference checks and annual performance appraisals. Missing was evidence of completed orientation programmes and checklists.	Nine staff files were reviewed, six of the nine files did not have documented evidence of completed orientation programmes and checklists.	Ensure that all staff complete orientation programmes and checklists. 90 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 infection control policies and medication policies in place that give clear guidance for staff around medication processes and the use of single use items. On the day of audit syringes appeared to be re-used.	On the day of audit, the downstairs medication room had empty syringes labelled with the previous contents in a clean bowl, there was no resident name or date. The RN explained that this was in case they need to give the medications again (to the same resident). The clinical manager explained that this was not the usual practice for the service and would investigate.	Ensure that single use syringes are not re-used. 30 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	Hot water temperatures are monitored monthly. The service adjusts the temperatures if they are over 45 degrees Celsius, however this has not addressed the ongoing issue of repeated high-water temperatures.	A review of water temperature in resident areas evidences that they have been over 45 degrees for seven out of 12 months in some areas of the home (46 to 48 degrees). The service advises that they have been adjusted each month, but this intervention has not sustained lower temperatures.	Ensure that water temperatures remain below 45 degrees in resident areas. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.