

Lexhill Limited - Kaikohe Care Centre

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Lexhill Limited
Premises audited:	Kaikohe Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 24 September 2018 End date: 25 September 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:	45

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Kaikohe Care Centre provides rest home, hospital (geriatric and medical) and dementia levels of care for up to 55 residents. On the day of the audit there were 45 residents.

This unannounced surveillance audit was conducted against a subset of 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 residents and staff files, observations, and interviews with residents, relatives, management, staff and the general practitioner.

An experienced aged care facility manager, who is a registered nurse, manages the service. Residents and family interviewed were complimentary of the staff.

The service has addressed four of the ten shortfalls from the previous audit around; corrective actions following audits, admission agreements, availability of call bells and qualified first aiders on each shift. There continues to be improvements required around; communication of internal audits at meetings, training for staff, care plan interventions, activities for residents, medication management and environmental maintenance.

This audit identified further improvements required around; family communication, completion of internal audits as per plan, timeframes for care planning and assessment, implementation of care plan interventions (including one high risk around wound care), evaluation of care plans, and service level approval for dementia care.

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.		Some standards applicable to this service partially attained and of low risk.
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Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. There is an established system for the management of complaints.

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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A manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is documented. The risk management programme includes managing adverse events and health and safety processes. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which

includes in-service education and competency assessments. Registered nursing cover is provided twenty-four hours a day, seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Registered nurses are responsible for all stages in the provision of care including interRAI assessments, risk assessments, development of care plans and evaluations. Resident files demonstrated service integration. Residents and family interviewed confirmed they were involved in the care plan process and review. The general practitioner or nurse practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provide an activities programme. Residents are encouraged to maintain links with community groups.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

The menu is designed by a dietitian. All baking and meals are cooked on-site. Individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours in all units.

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 medium or high risk and/or unattained and of low risk.
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The building has a current warrant of fitness.

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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The service has appropriate procedures for the safe assessment and review of restraint and enabler use. During the audit, seven residents were using restraints and two residents were using an enabler. Staff receive training around restraint minimisation.

Infection prevention and control

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

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	8	0	3	6	1	0
Criteria	0	33	0	4	6	1	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are readily available. Information about complaints is provided on admission. Interviews with three rest home and one hospital residents and families confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints. There is an online complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. Complaints are discussed at the monthly clinical quality meeting. There have been six complaints received for 2018. These were reviewed, and all were documented as resolved. Corrective actions have been implemented and any changes required were made because of the complaint. This includes one complaint which involved the Health and Disability Commissioner and DHB, this complaint was in process at the time of audit</p> <p>In response to the MOH letter dated 15th August 2018 around standard 1.2.7 and 1.4.2. The service has reviewed and increased staffing since the previous audit and safe staffing and skill mix has been addressed. The service has a proactive and reactive maintenance schedule in place and all appropriate equipment is available to the service.</p>
Standard 1.1.9: Communication	PA Low	An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes a range of information regarding the scope of services provided to the resident on entry to the service, and any items they must pay for that are not covered by the agreement. Interviews with four families

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		<p>(three from the dementia unit and one hospital) confirmed that they are kept informed. Five of eleven incident forms reviewed did not document if the family had been informed.</p> <p>The information pack is available in large print and can be read to residents.</p> <p>Interpreter services are available through the DHB if required. The facility manager reports that this has not been necessary. There were no residents at the facility who did not speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Kaikohe Care Centre provides rest home, hospital (geriatric and medical) and dementia levels of care for up to 55 residents. On the day of the audit there were 45 residents in the care centre (21 at rest home level, 18 at hospital level, including one respite and six at dementia level).</p> <p>An experienced facility manager is responsible for day-to-day operations. She had been a previous facility manager at this facility (2006-2011) and resumed responsibilities as the facility manager in June 2017. She is a registered nurse with a current practising certificate. (Link to 1.2.7.5). The facility manager is supported in her role by an experienced RN who has been in the role of Clinical nurse leader for a year</p> <p>Business goals are in place with evidence of regular reviews. The facility manager is in regular contact with the owner.</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 Moderate	<p>The service is in the process of implementing a quality and risk system introduced by an external consultant. This includes a system of internal audits, meetings, and reporting. An on-line data base that records collates, a range of quality out comes such as complaints, incidents and accidents and audits.</p> <p>Policies and procedures have been established with the assistance of an external consultant. Policies and procedures reflect evidence of reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes.</p> <p>The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, and skin tears and pressure injuries. Clinical quality meetings document that data had been collated from incident forms and results were communicated to staff. This is an improvement from the previous audit</p> <p>An internal audit schedule is in place, but not all audits have been completed as per the audit schedule and not all audit outcomes have been reported at facility meetings. Corrective actions have been documented for audits undertaken where opportunities for improvements were identified. This is an improvement from the previous audit.</p> <p>Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls, sensor mats and the availability of physiotherapy services.</p>

		<p>A recent resident and family survey has been collated and a report documented. This is on the agenda for the upcoming resident meeting and clinical quality meeting. This is an improvement from the previous audit.</p> <p>The health and safety programme meet current legislative requirements. It is overseen by a health and safety officer who is the maintenance officer and facility manager. The service is working with the union to engage staff representative as well. A health and safety induction programme are in place. Hazard identification forms and a hazard register are in place.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual paper-based incident reports are completed and entered onto the electronic system with immediate action noted and any follow-up action required. A review of eleven incident/accident forms from across all areas of the service, identified that all are completed and include follow-up by a RN. Required interventions are transferred to care plans. The service uses two incident forms, one for falls and a shorter form for non-resident related incidents. Neurological observations were documented following falls that were unwitnessed or included a head injury. The resident with the facility-acquired pressure injury (blister) had an incident form completed.</p> <p>The clinical manager is involved in the adverse event process, with links to the applicable meetings. The facility manager was able to identify situations that would be reported to statutory authorities. There has been one section 31 notification made post audit (link 1.3.6.1) and no outbreaks.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<p>Job descriptions are in place that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses and other health professionals were current. Five staff files were reviewed (two caregivers, one clinical nurse leader/RN and two RNs). Evidence of signed employment contracts and job descriptions were sighted. Annual performance appraisals for staff and an orientation were documented for all five, this is an improvement from the previous audit.</p> <p>The service has a training policy and schedule for in-service education. Caregivers working in the dementia unit who have been employed for over one year have their dementia qualification. In-service education continues to reflect low attendance rates. The manager has not accessed training related to managing an elderly care facility the last year and the IC coordinator has not undertaken training for an infection control coordinator.</p> <p>Competencies for RNs include medication and syringe driver. The service is implementing a process to ensure access to Careerforce for all staff.</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>	<p>FA</p>	<p>The service has a documented annual leave and rostering policy which includes rationale for determining staffing levels and skill mixes for safe service delivery. Since the previous audit the service has reviewed and increased staffing</p> <p>Staffing includes;</p> <p>Registered nurses; there is a registered nurse for every shift Monday to Sunday, plus the manager and clinical nurse leader Monday to Friday, who also provide on call.</p> <p>There is a full shift RN plus a half shift Monday to Sunday on the PM shift, and one on nights.</p> <p>Care staff</p> <p>Hospital AM; Two caregivers on full shifts and one caregiver on half shift, PM; two caregivers on full shifts and one caregiver on half shift. There was one caregiver on night shift.</p> <p>Rest home; AM; one caregiver on full shift and one caregiver on half shift, PM; one caregiver full shift and one caregiver on half shift. There was one caregiver on night shift</p> <p>Dementia; AM one caregiver on full shift and one caregiver on half shift, PM; one caregiver full shift and one caregiver on half shift. There was one caregiver on night shift</p> <p>The registered nurses provide over sight to the dementia unit. Staff in the dementia unit reported that the RNs visit often and are supportive. Family members interviewed stated the staffing was adequate. The facility manager reported that the roster can be changed to support resident acuity. The residents in the dementia unit can ether join other residents outside the unit for activities or caregivers assist with activities in the dementia unit. Caregivers in the dementia unit stated they are well staffed and are able to provide activities for residents. This is an improvement from the previous audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>PA Moderate</p>	<p>The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. Admission agreements were signed in all resident's sampled records, this is an improvement from the previous audit. Admission agreements reflect all the contractual requirements. Residents reported that the admission agreements were discussed with them in detail by the manager. Not all residents file includes a copy of the needs assessments on the day of audit.</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>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication reconciliation of monthly blister packs is completed, and any errors fed back to the pharmacy. Registered nurses and senior care assistants who administer medications have been assessed for competency. Appropriate medications were signed by two medication competent staff, one of which was a RN. The service uses paper-based medication system. Care staff interviewed could describe their role regarding medicine administration. Education around safe medication administration has been provided. Medications were stored safely in all three units (rest home, hospital and dementia unit). Medication fridge temperatures were monitored weekly. There were no residents self-medicating.</p> <p>Thirteen medication charts were reviewed: All medications had photographs, allergies documented and had been reviewed at least three-monthly by the GP. Not all medication had been signed for by the prescriber, not all as needed medication included an indication for use, not all short course medications included a stop date and not all eye drops had been dated on opening. This is a continued shortfall from the previous audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. The head cook oversees the provision of food services. A second cook and two kitchenhands provide cover across a seven-day service. All meals are prepared and cooked on-site. All kitchen staff had food safety training. There is a six-weekly seasonal menu. The food control plan in in the process of verification.</p> <p>Residents are provided with meals that meet their food, fluids and nutritional needs. The registered nurse completes the dietary requirement forms on admission and provides a copy to the kitchen. Additional or modified foods are also provided by the service. Cultural needs are catered for.</p> <p>Fridge and food temperatures were monitored and recorded weekly. Cooked meals are transferred into heated bain maries and transported from the kitchen directly to the dining rooms. The residents interviewed confirmed that they are provided with alternative meals as per request. Snacks are available in the dementia unit 24/7 All residents are weighed monthly. Residents with weight loss problems are provided with food supplements.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of</p>	<p>PA Moderate</p>	<p>All resident care plans demonstrated service integration. Assessments and care plans include input from allied health. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. One resident with an ostomy had care interventions documented well and included support and advice from the ostomy nurse. The long-term care plans reviewed did not all include support required to meet the resident's goals and needs, this is a continued finding.</p>

service delivery.		
<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>	PA High	<p>Care plans sampled were goal orientated. The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary.</p> <p>There were eleven wounds documented for the rest home and hospital at the time of the audit, there were no wounds in the dementia unit. A review of the wound register and interviews with management identified that the service only had one resident with a grade 2 pressure injury. A review of the wound register identified that this identified resident had no wound management plan in place. Assessments, management plans and documented reviews were in place for all wounds, but these were not always fully completed.</p> <p>Also, the wound register did not identify another large pressure injury (? unstageable) and a further smaller potential unstageable pressure injury for one resident. Both these pressure injuries were reported to the auditor post audit (following a complaint). The wound register only identified a heel and sacral skin tear for this resident. Wound photos reviewed post audit identified these were two-current pressure injuries. Pressure injury prevention and wound care training has not been provided in the last two years (link 1.2.7.5)</p> <p>Specialist nursing advice is available from the DHB as needed. A district nurse (wound care specialist) was not advised of current pressure injuries in a timely manner. A physiotherapist is available one day a week.</p> <p>Monitoring records were sighted; however, blood sugar monitoring was not consistently documented as completed.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</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>	PA Low	<p>The service employs two diversional therapists across five days a week with activities lead by the caregivers over the weekend. The diversional therapist interviewed displayed an understanding of requirements. All activities are supported by caregivers.</p> <p>The weekly activities are posted on a large whiteboard in the main hallway and on resident noticeboards in each area and include outings, baking, table tennis, bowls, bingo, church services and quizzes. The diversional therapy plans sampled reflected the resident's preferred activities and interests.</p> <p>Each resident has an individual activities assessment on admission and from this information an individual diversional therapy plan is developed. The diversional therapy plan evidences review at six-monthly at the multidisciplinary meetings, the plans for the residents in the dementia unit were not for 24 hours). The reviews document the resident's progress towards meeting goals. The resident's activities participation log was sighted. Residents interviewed indicated the activities provided by the service are adequate and enjoyable.</p> <p>Activities documented on the plan are appropriate to the needs, age and culture of the residents. Residents from the dementia unit join other residents in the rest home for activities or remain in the unit and enjoy activities with</p>

		caregivers.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans reviewed (except one) had been evaluated by registered nurses for long-term residents who had been at the service six months and longer (link 1.3.3.3). Written evaluations for long-term residents describe the resident's progress against the residents identified goals and any changes are updated on the long-term care plan for two of six files (One was respite four were not due). There is documented evidence that care plans are updated for change of health status (link 1.3.5.2).</p> <p>There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</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>	PA Moderate	<p>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. The facility has a current building warrant of fitness (expires 30 June 2019). The fire evacuation scheme document reviewed was approved 25 June 2007.</p> <p>Maintenance is undertaken by both internal maintenance and external contractors. Electrical safety tests have been documented annually. Some areas requiring maintenance were observed during the audit and this is a continued short fall from the previous audit. Review of the records reveals water temperatures are all below 45 degrees Celsius and whenever it was out of range, corrective actions had been taken.</p> <p>All areas including showers has call bell access, this is an improvement from the previous audit.</p> <p>Refer 1.4.7. There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate. This is an improvement on the previous audit.</p> <p>All external areas inspected are safe and include appropriate seating and shade. The lounges are carpeted or have vinyl floor coverings, dining rooms and hallways have vinyl floor covering, bedrooms have a mix of carpet and vinyl. The front outdoor area has a tarmac and gravel driveway with grassed areas and flower beds.</p> <p>The service has a maintenance schedule in place around equipment. There is appropriate equipment available at the service. Equipment includes; one standing hoist, one sling hoist, five wheelchairs, 22 walking frames, two zimmer frames, four sensor mats, three gutter frames and seven commodes. All of this equipment was included in a preventative maintenance schedule. Staff interviewed stated there was enough equipment available and equipment is replaced as needed.</p>
Standard 3.5:	FA	The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for

<p>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>all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention officer completes a monthly report. Monthly data is reported to the service meetings. Staff are informed through the variety of clinical meetings held at the facility. The infection prevention and control programme links with the quality programme. There liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. On the day of audit, there were seven residents with restraints in the rest home and hospital (seven bedrails and one safety vest) and none in the dementia unit. There were two residents using an enabler. Two resident files reviewed for restraint had all appropriate assessments and reviews in place. Staff training has been provided around restraint minimisation and challenging behaviour (link to 1.2.7.5).</p> <p>There is documented discussion in the RN meeting the shows they are working to reduce restraint use.</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)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	The service has an open disclosure policy and RN interviewed stated that family are informed following and incident or accident. This was not always documented.	Of the eleven incident forms reviewed, five did not evidence that family / EPOA had been informed post incident.	Ensure that family are informed of incidents and accidents and this is documented. 90 days
Criterion 1.2.3.6 Quality improvement data	PA Moderate	The service has implemented the meeting template provided by the external contractor for the clinical quality meeting. The meeting minutes	Quality meeting minutes for April, May and July 2018 documented that audits had been undertaken, they did not document which audits or any outcome from the audits.	Ensure the meeting document the internal

are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.		template covers all essential reporting. The service documents discussion against all agenda items such as (but not limited to) falls, infections, restraint, and skin tears, but does not always document the audits undertaken or the outcomes from audits completed.		audits, the outcome and any actions needed. 30 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	The quality and risk programme has a documented internal audit schedule. The facility manager has been undertaking audits to target specific issues rather than completing the set audits and adding additional audits as needed. Three recent months sampled (June July and August 2018) evidenced that not all audits are being undertaken as scheduled	Not all internal audits have been undertaken as per schedule, examples include; admission audit, care planning audit, continence audit, privacy audit and recreation/ activities audit.	Ensure that all internal audits are undertaken as scheduled 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	The service has an implemented education schedule documented that provides more than the contract training hours for each staff member. All training has been provided as per the schedule, however attendance continues to be low. All 14 caregivers that work in the dementia unit have completed their dementia standards. There are currently three of nine RNs interRAI trained.	(i)For all training reviewed for 2018, less than 50 % of staff have attended. (ii) The manager has not attended at least eight hours of training relevant to her role; and (iii) the IC coordinator has not attended training relevant to her role; (iv) pressure injury prevention and wound care training has not been provided in the last two years.	(i)Ensure staff attend all mandatory education and training and can demonstrate that they have each attended eight hours annually. (ii) – (iii) Ensure that the manager and

				<p>IC coordinator attend training relevant to their roles. (iv) Ensure pressure injury prevention and wound care training is provided.</p> <p>90 days</p>
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	<p>PA</p> <p>Moderate</p>	<p>Pre-admission information packs include information on the services provided for resident and families. Admission agreements for long-term residents aligned with contractual requirements. Exclusions from the service are included in the admission agreement. Not all residents have a copy of the NASC approval for services or an EPOA.</p>	<p>Two of two resident files in the dementia unit did not include a copy of a NASC assessment conforming eligibility for a secure dementia unit, or a copy of the resident's EPOA. Since the draft report the provider stated, the NASC approval for Dementia level care is emailed to us and we print it off and keep it in a folder in the main office. Regarding EPOA status this is not always available to be obtained from the family as cost seems to be a barrier. But the service does request the family for a copy and keep it in the main office for safe keeping.</p>	<p>Ensure that all resident in the dementia unit have a copy of their eligibility for a secure unit and a copy of their EPOA</p> <p>30 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to</p>	<p>PA</p> <p>Moderate</p>	<p>There are policies and procedures in place to safe guide staff and to manage the medication process. The medication round observed evidenced good practice by the RN when administering medications. Not all</p>	<p>(i) Rest home; one of five medication charts did not have all regular medication signed by the prescriber.</p> <p>(ii) Four of eight medication charts (two hospital, two dementia) did not have all regular medication signed for by the prescriber, two medication charts (one hospital, one</p>	<p>(i) Ensure that all medication is signed for by the prescriber (ii)</p>

manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		medication in the medication charts had been signed by the prescriber (the GP), not all as needed medication included a documented indication for use, and stop dates were not always in place for short term medication. Not all eye drops were dated on opening.	dementia) had a short course medication with no stop date and two of four (one hospital, one dementia) included an 'as required' medication with no 'indication for use'. (iii) The hospital and rest home medication trolleys both included undated eye drops.	Ensure that short term medication have a documented stop date. Ensure that as needed medication include a documented 'indications for use'. (iii) Ensure that eye drops are dated on opening. 60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	The service has three interRAI trained registered nurses. The service schedules when interRAI assessments are due and all interRAI assessment for the four long-term residents had been documented six monthly (one was respite). New residents were not always assessed within time frames and new long-term care plans were not always documented within time frames. Care plan evaluations were not always completed 6 monthly.	(i) Two of two dementia resident's interRAI and long-term care plan were not documented within 21 days. (ii) Two of three rest home resident files reviewed for timeframes did not have the interRAI and long-term care plan within 21 days (sample increased). (iii) One dementia resident clinical care plan had not been evaluated or updated since October 2017.	(i)-(ii) Ensure that the interRAI assessment and long-term care plans are documented within set timeframes. (iii) Ensure that evaluations are documented six monthly

				90 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Care plans are in place for all residents. Staff inform that they are easy to follow and understand. Care plans did not reflect all resident needs. This is a continued finding from the previous audit.</p>	<p>(i) Two hospital level resident care plans did not include interventions to support all assessed needs; (a) one resident had no nursing interventions to support pain (where pain was an issue). (b) the respite resident care plan did not identify that the resident was an amputee and did not document interventions for safe smoking. This resident's initial care plan was not fully completed.</p> <p>(ii) One rest home resident included the treatment of hypoglycaemia documented, but not how to recognise the symptoms. (iii) one rest home resident's initial care plan was not fully completed. (iv) one resident (dementia unit) did not include interventions to manage wandering into other rooms, (v) one resident (dementia) care plan had not been updated to reflect changes in care when the resident moved from the rest home into the secure dementia unit.</p>	<p>Ensure that all care plans have documented interventions to address all current assessed needs</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA High</p>	<p>The families interviewed were positive about the care provided at Kaikohe care centre. The nurse practitioner (NP) interviewed stated that they had noticed that 'acute conditions' and call outs had reduced. RNs are caregivers were able to describe the care needs and monitoring for residents. However, this was not always documented as provided and there was confusion around wound management and responsibilities. Wound care plans were not documented for all wounds. Following the audit, a complaint regarding lack of pressure injury care and wound management has been received by the</p>	<p>(i) One hospital level resident did not have ongoing pain assessments to monitor reported pain. Since the draft report that provider stated; a review of the resident's pain assessment started on the 27/09/2018 to 28/09/2018. The review only evidenced one episode of moderate pain intermittent managed with analgesic. Which was measured again on the 28th for 12 hours. The RN on the afternoon duty contacted the Hospice Nurse to have pain management plan in place if the condition worsens. Hospice Nurse visited onsite on the 27th and charted a pain management plan. This same resident did not have a wound management plan documented for the stage 2 pressure injury. (ii) One rest home resident did not have blood sugar levels (BSLs) completed and documented as per the care plan. (iii) One resident had two potentially unstageable pressure injuries that have come to the attention of the lead auditor and DHB post on-site audit. These wounds have not been identified as</p>	<p>(i)-(ii) Ensure that resident monitoring is completed and documented according to the care plan and assessed needs.</p> <p>(iii) Ensure that wound management plans are in place and</p>

		DHB. A review of the auditor field notes identified the pressure injuries and wound documentation referred to in the complaint were not available to the auditor on the day of audit and not included as part of the wound register. A section 31 has since been completed for the pressure injury post audit	pressure injuries in their wound register and current best practice wound management practices were not being implemented to effectively manage the wound. A section 31 has since been sent to HealthCERT which identified a stage 3 pressure injury. Since the draft report the provider has stated, wound care practices were implemented on alternate days as the per plan to manage the wounds.	implemented for all identified wounds, and specialist input is obtained in a timely manner. 7 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	All resident files reviewed documented an activity plan. Resident care plans did not reflect activities across 24-hours for those residents in the dementia unit.	Two of two dementia unit residents care plans did not document a 24-hour approach to activities.	Ensure that dementia residents have a 24-hour activity plan documented 60 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	The environment was warm and very clean, one unsafe area was cordoned off. There was a number of maintenance issues that needs addressed.	The environment has areas that require repair. (i) Rest home; the dining room has had a water leak and one area is cordoned off (the plumber had been contacted). (ii) Hospital; one bathroom had peeling paint and a cracked sink; the lounge has chipped paint on the skirting boards. A shower has loose boards (where the shower chair was removed from the wall and replaced with a board), chipped shower liner and peeling paint on the ceiling. (iii) Dementia; a toilet wall has cracked walls, peeling paint, there a cracked sink in one bathroom and a shower has a cracked liner and peeling paint	Ensure all reactive maintenance issues are addressed. 60 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, 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.