

Kaylex Care (Waipukarau) Limited - Mt Herbert House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Kaylex Care (Waipukarau) Limited
Premises audited:	Mt Herbert House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 January 2019 End date: 10 January 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	36

Executive summary of the audit




Introduction


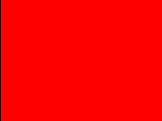
This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- 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

Mt Herbert House provides rest home and hospital level care for up to 42 residents. The service is operated by Kaylex Care, a small, privately owned group of three aged care facilities. Mt Herbert House is in Waipukurau, Central Hawke's Bay and is managed by a facility manager and a clinical nurse manager. The General Manager of Kaylex Care Group was also present at the audit. There have been no changes to the service since the last onsite audit. Residents, families and external stakeholders spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, contracted health providers and a general practitioner.

This audit has identified two areas requiring improvement relating to the lack of detail in residents' care plans and the restraint minimisation and safe practice policies and procedures, which do not include all the requirements of the standards.

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.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

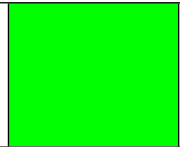
Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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



Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and philosophy of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using electronic and hard copy files.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

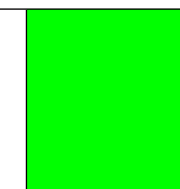
Care plans are based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files are reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

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

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

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

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.		Some standards applicable to this service partially attained and of low risk.
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The organisation has implemented policies and procedures that support the minimisation of restraint. The organisation has recently changed their restraint policies and procedures. They have a no restraint philosophy. Prior to mid-2018 there had been no use of restraint since 2011.

One resident was using a restraint at the time of audit. An assessment, approval and monitoring process with regular reviews occurs. There is a process for the use of enablers to ensure they are used voluntarily for the safety of residents in response to individual requests. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an appropriately trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board. The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken, data is analysed, trended and benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	48	0	1	1	0	0
Criteria	0	99	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Mt Herbert House (Mt Herbert) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed showed that informed consent had been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent was defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The Kaylex Care complaints policy provides for all complaints – verbal or written, identified or anonymous – to be received and acted upon at any Kaylex Care facility.</p> <p>Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that one formal complaint had been received in 2018 and that actions taken, through to an agreed resolution, were documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. Staff interviewed confirmed an understanding of the complaint process and their responsibilities for reporting complaints.</p> <p>The facility manager reported that she addresses minor issues for residents on a one to one basis either directly or through the monthly residents' meetings. The residents' meeting minutes recorded discussions of issues raised by residents and an immediate response and resolution or later follow up and resolution. The family satisfaction survey indicated that family/whānau also have access to the complaints process.</p> <p>There have been no complaints received from external sources since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas. Information on the Code, advocacy services, how to make a complaint and feedback forms are available in the entry foyer.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families of Mt Herbert confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and during discussion with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Documentation, observation and interviews verified there were three residents at Mt Herbert at the time of audit who were Maori, however they did not identify as Māori. There were several staff who identified as Māori. A staff member is the appointed cultural officer, identifies as Māori and has had training in the Treaty of Waitangi. Interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers.</p>
<p>Standard 1.1.6: Recognition And</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that</p>

<p>Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>staff respected these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A family satisfaction questionnaire and residents' meeting minutes included evaluation of how well residents' cultural needs are met, and this supported that individual needs were being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Interviews with a general practitioner (GP) and a social worker expressed satisfaction with the standard of services provided to residents at Mt Herbert.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals (for example, the hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care specialist, community dieticians, services for older people, gerontology nurse specialist), and education of staff through the availability of on-line learning sites.</p> <p>New graduates employed at Mt Herbert are supported by the Hawke's Bay District Health Board (HBDHB) to participate in their Nursing Entry to Practice (NETP) programme. RNs are supported to attend post graduate training provided by the HBDHB and the local hospice. All RNs are syringe driver competent and all care assistants have completed or are in training to attain the National Certificate in Care of the Older Person, level 3 or level 4. Mt Herbert offers employment opportunities for caregivers trained in aged care by the local technical institute, when required.</p> <p>The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks, such as on-line forums, to support contemporary good practice.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the HBDHB when required. Staff knew how to do so, and brochures on the service were easily accessible. Staff reported interpreter services were rarely required due to all present residents being able to 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>	<p>FA</p>	<p>Kaylex Care is a privately owned group of three aged care facilities in the North Island. The owner / directors live in Auckland. There is a general manager who undertakes financial management responsibilities for the group based in Auckland. There is one facility in Hamilton, one in Manawatu and Mt Herbert House is based in Waipukurau in Central Hawkes Bay.</p> <p>There is a strategic business plan which is reviewed annually. The current Kaylex Care strategic business plan is dated 2018 – 2019. As well as outlining the purpose, values, scope, direction and goals of the organisation.</p> <p>The service is managed by facility manager who is a registered nurse. She has been in the position seven years and was a registered nurse (RN) at Mt Herbert House for three years prior to being appointed to the facility manager role. She has attended nursing management training and undertakes professional development to maintain her nursing practising certificate. Responsibilities and accountabilities are defined in a job description and individual employment agreement. During interviews, the facility manager confirmed knowledge of the sector, regulatory and reporting requirements. The facility manager is supported in her role by the director, who has nursing and management experience, and the general manager.</p> <p>A sample of monthly reports to the director and the general manager showed adequate information to monitor performance is reported including financial performance, emerging risks and issues and resident related data (see also standard 1.2.3).</p> <p>The service holds contracts with the Hawke's Bay District Health Board (HBDHB) aged related residential care including long term chronic health conditions. (End of life care is currently provided under this contract). Mt Herbert House also holds a contract with the Ministry of Health for the provision of residential services for people under the age of 65, and a contract for day care</p>

		<p>/ day programmes with the Central Hawkes Bay Health Trust although this is not subject to this audit process.</p> <p>One the first day of the audit 36 residents were receiving services; 17 at rest home level and 19 at hospital level. Two of the residents receiving hospital level care were both under 65 years of age and funded under the long term chronic health conditions contract with HBDHB.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the short term absence of the facility manager, the clinical nurse manager will undertake the role of acting facility manager. They are supported in this by the director who is available by phone on call. The clinical nurse manager, at the time of the audit, is retiring from this position and taking up an RN role. A senior registered nurse, who has worked at Mt Herbert House for six years, will be taking up the position of clinical nurse manager. She has been transitioning into the role for the past six months and was available throughout the audit.</p> <p>Staff members reported their confidence in the senior RN and the structure for a temporary absence of the facility manager.</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>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes an annual quality plan, with objectives specific to Mt Herbert House, and a risk management plan which identifies and manages business risks.</p> <p>Meeting minutes were available and reviewed. A monthly review and analysis of quality indicators and related information is reported to the director and general manager. This information is discussed at the quarterly staff meetings and RN meetings. The analysed quality indicators and graphed information is then available in the staff room for those staff who are unable to attend these meetings. Evidence of this occurring was seen during the audit and staff reported their involvement in these meetings and their ability to take part in discussions. They also receive information about internal audit activities and any relevant corrective actions which are developed and implemented to address any shortfalls.</p> <p>Residents have a regular monthly meeting with the manager, and family satisfaction surveys are completed annually. The most recent survey, completed in December 2018, had positive feedback overall from families and whānau.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and</p>

		<p>removal of obsolete documents. All policies reviewed during the document review and onsite audit were current and had been reviewed within the time frames identified in the organisation's policy.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the director in the facility manager's monthly reports. Copies of these reports were reviewed during the audit and have been completed consistently with sufficient information to the directors and general manager.</p> <p>The facility manager described essential notification reporting requirements. They advised there have been no notifications of significant events made to the Ministry of Health since the previous audit. They understood their responsibilities for such notifications and those to other external agencies.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and an annual performance review for all staff members is completed.</p> <p>Continuing education is planned on an annual basis which includes mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. All Mt Herbert House staff hold or are completing NZQA qualifications or they are qualified health professionals (RNs and / or enrolled nurses).</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated</p>

		completion of the required training and completion of annual performance appraisals. All Mt Herbert House RNs also have a Nursing Professional Development Recognition Programme (PDRP) portfolio which is assessed through HBDHB.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility manager adjusts staffing levels to meet the changing needs of residents. An afterhour on call roster is in place, with both the facility manager and clinical nurse manager available on call. Staff reported that there is good access to advice when needed.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of four weeks of the roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</p> <p>There are housekeeping, kitchen, maintenance and gardening staff members who also complement the care staff team. A full-time diversional therapist is employed.</p> <p>The facility manager has previously had an operational role within the Kaylex Care Group. She no longer holds this role, having decided to focus solely on her role at Mt Herbert House. This change in position occurred from October 2018.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents are admitted to Mt Herbert when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the clinical nurse manager (CNM). They are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the HBDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services, in addition to an interRAI referral. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</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>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. RNs administer all medicines and are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the</p>

		<p>commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN, CNM and FM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</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 is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in November 2018. Several recommendations made around the advice to increase food quantities, have been implemented.</p> <p>A food control plan was registered through Aged Care Providers (29 May 2018). All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, family satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were enough staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is</p>	<p>FA</p>	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are</p>

<p>declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents of Mt Herbert are initially assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity and nutritional screening, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents' changing conditions require.</p> <p>In all files reviewed, initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments were completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verified the RNs were familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs.</p> <p>All residents had current interRAI assessments completed by one of three trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Ten care plans reviewed reflected the generalised support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in the care plans reviewed; however, the potential risks associated with assessment findings, some medical conditions, and individualised needs were not well documented.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and</p>	<p>FA</p>	<p>Documentation, except for that referred to in criterion 1.3.5.2, observations and interviews verified the provision of care provided to residents was consistent with their needs and goals and plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in</p>

<p>appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation, verbal handovers, from knowledge of the resident and their training. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A trained diversional therapist provides the activities programme. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review. A trial period of offering activities in the weekend was discontinued as residents showed little interest.</p> <p>A facility van is available for outings, though does not have a hoist to enable wheelchair access. A community van can be accessed when the use of a hoist is required.</p> <p>The planned monthly activities programme sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included bowls, visits to and from other rest homes, attendance at community events, visits by community agencies word games, Tai Chi, quiz sessions and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Family satisfaction surveys demonstrated satisfaction with the activities programme, and any suggestions for improvement were used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p> <p>There are two residents under 65 years at Mt Herbert. One of these residents is enabled to be actively involved with activities in the community. The other is provided with one to one activities in line with the resident's interests.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. The RN documents evaluations. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for infections and pain, and progress</p>

		<p>evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Photographs are used to evidence wound care evaluation. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Kaylex Care has documented processes for the management of waste, infectious and hazardous substances. These are available for staff members, along with material safety data sheets for all cleaning and laundry chemicals and products used at Mt Herbert House. These were on display in the laundry, utility room and kitchen.</p> <p>Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p> <p>Staff members responsible for the management of waste were interviewed during the audit and were familiar with the organisation's procedures.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 7 March 2019) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with the maintenance personnel and observation of the environment. The environment</p>

		<p>was hazard free, residents were safe, and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. There are external areas, with shade and seating, which are accessible for residents and they were observed to use these during the days of the audit.</p> <p>Resident, family and whānau feedback was positive about the facility.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes ten bathrooms and 14 toilets specifically for resident use. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> <p>Additional toilets are available for staff members and visitors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents and families reported the adequacy of bedrooms. Residents were observed to move independently around their bedrooms during the audit visit, or with assistance for those people who require this.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access additional areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry by dedicated housekeeping staff members. Housekeeping staff on duty on the days of the audit demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Residents'</p>

<p>hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>meetings minutes record satisfaction with the cleaning and laundry services.</p> <p>There is a designated housekeeping team who undertake the cleaning and laundry services. They have received training and hold appropriate qualifications, as confirmed in interview and review of cleaning staff training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through regular internal audits conducted quarterly. No major issues have been noted on internal audits conducted and any minor issues identified were rectified.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is a documented disaster and civil defence plan which guides the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 4 September 2018. The plan was updated in relation to the chalets which are adjacent to the aged care facility and are subject to a separate contract with the Ministry of Health but does not come under certification to these Standards. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 4 October 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets and gas BBQ's were sighted and met the requirements for the number of residents and staff at Mt Herbert House. There is a 2000 litre emergency water storage tank located on the premises and there is a generator available. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Monitoring of call bell response times is completed through an internal audit and residents and families confirmed that staff respond promptly to call bells. This was also observed to occur during the days of the audit.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time in the early evening, checked during the night shift and unlocked at the time of the morning shift handover.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	<p>FA</p>	<p>All residents' rooms and communal areas have heating in winter, electric fans in summer and ventilation. Rooms have natural light, opening external windows and curtains which were in</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>good condition and provided adequate coverage of the windows to provide shade and privacy when needed.</p> <p>Heating is provided by electric wall heaters in residents' rooms and in the communal areas. Areas were well ventilated and electric fans were available throughout the audit. Residents and families confirmed the facilities are maintained at a comfortable temperature, as much as possible, in a hot, Hawke's Bay summer.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the CNM and FM. The infection control programme and manual are reviewed annually.</p> <p>The CNM with input from the FM is the designated infection control nurse coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the FM and tabled at the staff meetings. Infection control statistics are entered in the organisation's electronic database and benchmarked against previous data.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator (ICC) has appropriate skills, knowledge and qualifications for the role. The ICC has undertaken post graduate training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC and FM confirmed the availability of resources to support the programme and any outbreak of an infection.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC and FM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. The data was displayed in the staff room.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Mt Herbert House has a philosophy of not using restraints if at all possible. From 2011 until mid-2018 there had been no use of restraints in the facility.</p> <p>At the time of the audit the restraint coordinator was the clinical nurse manager. A senior registered nurse will be taking over both of these roles (clinical nurse manager and restraint coordinator) immediately after the audit. Both were interviewed in relation to this Standard along with the facility manager.</p> <p>On the day of audit, one resident was using a restraint. No residents were using enablers. The three senior staff members demonstrated an understanding of their philosophy of no restraint use, exploring alternatives whenever possible, and if not possible, using the least restrictive option available.</p> <p>Restraint approval group minutes were available and these showed quarterly meetings and a history of no restraint use since 2011 until the recent use in 2018. Interviews with staff members confirmed that they have regular annual training and new staff have training after their orientation.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>PA Low</p>	<p>There was evidence of the restraint in use for one resident at the time audit, and briefly in mid-2018 two other residents had restraints for two months and one month. The restraint in use at the time of this audit had been approved by the restraint coordinator, family member and GP. The consent form was signed by all parties as described in policy within several days of the resident's admission to Mt Herbert House.</p> <p>Annual training in the use of enablers and restraints is provided. This includes competency assessments. Evidence of annual training at Mt Herbert was seen. This occurred in October 2018 and all relevant staff members attended. This included all RNs and care assistants and the diversional therapist. The frequency of training is determined by the facility manager and director of Kaylex Care.</p> <p>The organisation's process for the use of restraint has been implemented for the resident who requires the ongoing use of the restraint – a chair brief restraint – and the protocols for the restraint use are being followed. The group-wide policy provides guidance in meeting the main requirements of these standards, but some criteria are missing. The process also needs to be improved to make the consideration and use of restraint more straightforward, for example: there is no formal assessment process, or assessment form included, only information to be considered when assessing the need for a restraint.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The resident using restraint at the time of the audit has had an assessment. They were admitted to Mt Herbert House on 24 July 2018. The restraint coordinator reported that they were brought to the facility by a family and a member of the DHB's referral agency, but no verbal handover of the resident's needs and the existing use of the restraint was given on arrival. The interRAI care plan information was made available to Mt Herbert House on 25 July 2018.</p> <p>The restraint coordinator reported that they had completed an assessment for restraint after they identified, with input from the resident's family, that the resident had used the lap belt restraint at the facility where they had moved from. The family consented to the continued use of the restraint at Mt Herbert. This consent is recorded on the restraint consent form on file.</p> <p>The general practitioner was also involved in the final decision on the use of the restraint, and this is recorded on the consent form. The desired outcome was to ensure the resident's safety and security. Completed assessment information was sighted across a range of documents; progress notes, a short term care plan and family /whānau communication notes on the resident's file, However, other than the restraint consent form, the assessment information was in multiple places and not easy to find.</p> <p>The organisation's documented policy on assessment involves identifying the behaviour that poses a risk of injury to the resident, why it is a problem, the solution and why restraint is the method of choice.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised at Mt Herbert House and the restraint coordinator, facility manager and senior RN described how alternatives to restraints are discussed with staff and family members. This includes the use of specialist memory foam mattresses for hospital residents, which has eliminated the need for bed rails, sensor mats, and high/low beds.</p> <p>When restraints are in use, half hourly monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details of the resident being checked, toileted, taken for a walk, having a change of environment. Access to advocacy is available, if requested, and all processes ensure dignity and privacy are maintained and respected.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p> <p>A restraint register is maintained, at each monthly restraint approval group meeting. The register was reviewed and contained details of the residents who had had restraints over the past year</p>

		(three), including the one resident currently using a restraint. This provided sufficient information to provide an auditable record.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of the resident's file showed that the individual use of their restraint is reviewed and evaluated three monthly. A restraint approval group meeting is held every three months as well. The family of the resident with the restraint was not available to be interviewed although progress notes record their involvement in decision making and other communication with them.</p> <p>The evaluation is recorded by the restraint coordinator, on the resident's care plan. At interview with the restraint coordinator and the senior registered nurse they understood the requirements of the standard. Future options to eliminate the use of the restraint have been explored.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>There are minutes of quarterly meetings of the restraint approval group, however there has been no quality review process yet. The use of restraints for the current resident (and very briefly two others in 2018) has all occurred within the last six months.</p> <p>The use of restraint is reported in the monthly quality improvement data by the facility manager. The facility manager, restraint coordinator and senior registered nurse reported that use of restraint is discussed at the restraint approval group meetings and at the registered nurses meetings.</p> <p>No time frame for quality review of restraint has been determined in the Kaylex care policy. This is referred to and included in the finding made against Standard 2.2.1.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</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</p> <p>Moderate</p>	<p>Ten residents' files were reviewed. Seven out of ten did not fully describe the required support the resident needed to address the assessment findings. Five of the ten files identified residents having a low or moderate risk of developing pressure injuries. The plan in place addressed the risk from a generalised perspective; however, did not address individualised needs.</p> <p>Air mattresses were instigated after an actual injury occurred, formal turning charts, improved nutritional requirements and a review of preventative management strategies to assess effectiveness, as well as the plan to seek advice from an occupational therapist for one resident. Four of the residents' reviewed, where they were identified as being at risk, developed pressure injuries requiring wound care management. Two of the four also had previous medical concerns with one also having recent weight loss. No strategies were in place to identify the management or</p>	<p>Care plans reviewed did not always describe fully the required support the resident required in seven of the ten files reviewed.</p>	<p>Provide evidence that residents' care plans fully describe the care the resident requires to meet the desired outcomes.</p> <p>60 days</p>

		<p>indicators of exacerbation or recurrence.</p> <p>The fifth resident (refer hospital resident tracer 1.3.3.3) was identified as being at risk and had well documented preventative strategies; however, the documentation on the turning chart did not evidence compliance with the requested regime. The need to provide a number of complex nursing management strategies around behaviour, hygiene, care of a percutaneous endoscopic gastrostomy tube (PEG) and care of the resident's mouth, was not documented, although observation indicated management of these aspects of the resident's care was occurring.</p> <p>A sixth resident on a behavioural monitoring chart that indicated behavioural issues had no specific behaviour plan that described how best to manage the behaviour specifically for this resident.</p> <p>The seventh resident on restraint, had no plan in place to address the needs of the resident while the restraint was in use.</p>		
<p>Criterion 2.2.1.1</p> <p>The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.</p>	PA Low	<p>Kaylex Care has a no restraint philosophy and this is evident in their not using restraint at all from 2011 until mid-2018. An approval process is described in the policy, with accountability for restraint use, guidance for obtaining consent from family /whanau or an EPOA and input from the resident's GP. At the time of the audit only one resident had an approved restraint which was documented and there are records on their file consistent with the policy requirements.</p> <p>However, limited information is recorded due to the lack of direction and guidance in the group-wide policy.</p>	<p>The Kaylex Care Group policy does not provide sufficient detail to effectively meet all requirements of these standards, especially for Mt Herbert House which has not used restraints for seven years. In particular, there is no information to guide the restraint approval group on conducting a quality review of restraint use (refer standard 2.2.5) when the time comes for this to occur.</p>	<p>Review the policies and procedures for the use of restraint and enablers for Kaylex Care Group against the requirements of these standards and ensure that all requirements are met.</p>

				90 days
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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.