

# Lexhill Limited - Kaikohe Care Centre

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** 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: 14 March 2019 End date: 15 March 2019

**Proposed changes to current services (if any):** This audit also reviewed the dementia unit for capacity for a further bed (from nine to ten beds). The service has an email from the DHB approving the use of the tenth room and a respite resident was occupying the room. At the time, of audit there was no notification to the ministry of health for the additional room. The additional bedroom is fit for purpose. The room was originally used as the nurse's station. This has meant that the computer, phone, any nursing notes and medication trolley (locked) were stored in the foyer at the time of audit. There was no designated staff space to

discuss residents in privacy. The dining room has space for only nine chairs, and the lounge has only eight easy chairs with no room for further chairs. For these reasons the dementia unit has not been verified as suitable to increase to 10 beds.

**Total beds occupied across all premises included in the audit on the first day of the audit: 48**

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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 48 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, she has been in the role since February 2019 and is supported by two acting clinical nurse leaders, whilst the permanent nurse leader is on leave. Residents and family interviewed were complimentary of the staff.

The service has addressed five of the eleven shortfalls from the previous audit around; family communication post incident, frequency of meetings, the internal audit process, training for staff and resident's entry to services. There continues to be improvements required around; timeliness of assessments and care plans, care plan interventions, implementation of care, activities programme, medication management and environmental maintenance.

This audit identified further improvements required around; complaints management and staffing.

## 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 a 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 is 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 implemented. 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.

## 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 completes an admission visit and reviews the residents at least three-monthly.

The activity team provide an activities programme.

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 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 one resident 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	10	0	2	4	2	0
Criteria	0	36	0	2	4	2	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.	PA Low	<p>The service has a complaints policy that describes the management of the complaints process, however this has only recently been implemented from February 2019. Complaints forms are readily available. Information about complaints is provided on admission. Interviews with two rest home and two hospital residents and families confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints.</p> <p>There is an online complaint's register, (commenced February 2019) that includes written and verbal complaints, dates and actions taken demonstrates that complaints are being managed in a timely manner. Prior to February the service utilised a paper-based system (but logged complaints onto an online system). Not all complaints since the previous audit and prior to February 2019 document follow-up and reply to the complainant, and not all complaint documentation was available at the time of audit.</p> <p>Complaints are discussed at the monthly staff/quality meeting.</p> <p>One complaint which involved the Health and Disability Commissioner and DHB has been resolved.</p>
Standard 1.1.9: Communication	FA	<p>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 two family</p>

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		<p>members (one from the dementia unit and one hospital) confirmed that they are kept informed. Seven of seven incident forms reviewed documented that the family had been informed. This is an improvement from the previous audit.</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 reported that this has not been necessary.</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, 24 beds are dual purpose beds. On the day of the audit there were 48 residents in the care centre; 23 at rest home level, 15 at hospital level, and 10 at dementia level. All residents were under the ARCC contract.</p> <p>The service is certified for nine dementia beds; however, the service has an email from the DHB providing permission for an additional bed for a respite dementia bed. The Ministry of Health had yet to be informed. This audit has not verified that the current configuration of the dementia unit as suitable for an additional bed (link 1.4.2).</p> <p>An experienced facility manager is responsible for day-to-day operations. She has been in the role since February 2019 and is an experienced registered nurse and elderly care manager. The facility manager is supported in her role by two acting clinical nurse leaders, whilst the current clinical nurse leader is on maternity leave.</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>	FA	<p>The service has a quality and risk system that was introduced by an external consultant. This includes a system of internal audits, meetings, and reporting. An on-line database records and collates a range of quality outcomes 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. Staff/quality meetings have been held regularly and document that data had been collated from incident forms and results were communicated to staff as well as internal audits, infection</p>

		<p>control, health and safety and restraint. This is an improvement from the previous audit.</p> <p>An internal audit schedule is in place, and audits have been completed as per the audit schedule. 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>Resident meetings have been held two monthly and a satisfaction survey was in process of being completed at the time of report.</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>The health and safety programme meets 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 a staff representative as well. A health and safety induction programme is 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 incidents are entered onto the electronic system with immediate action noted and any follow-up action required. A review of seven falls related incident/accident forms from across all areas of the service, identified that all were completed and included follow-up by a RN. Required interventions identified from the incident forms were transferred to care plans where required. Neurological observations were documented following falls that were unwitnessed or included a head injury. The resident with the facility-acquired pressure injury (now healed) had an incident form completed.</p> <p>The clinical nurse leaders and facility manager are 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 no section 31 notification made since the previous audit and no outbreaks.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	FA	<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 RN, one cook and one diversional therapist). Evidence of signed employment contracts and job descriptions were sighted. Annual performance appraisals for staff and an orientation were documented in all five staff files reviewed and this is an improvement on previous audit.</p> <p>The service has a training policy and schedule for in-service education. Caregivers working in the dementia</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>unit who have been employed for over 18 months have their dementia qualification. The service has made training a priority since the previous audit, with a wide range of compulsory and non-compulsory subjects provided. Training has included; wound care, pain management, falls, clinical assessment, and a range of infection control related training. Training has been well attended; this is an improvement from the previous audit. RN specific training has included syringe driver, wound care and skin care. All staff who administer medications have an up-to-date medication competency. There are four interRAI trained RNs.</p> <p>The manager has accessed training related to managing an elderly care facility in the last year and the IC coordinator has undertaken training for an infection control coordinator. This is an improvement from the previous audit.</p> <p>The manager is a Careerforce assessor and the service is continuing to support Careerforce training 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>PA High</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.</p> <p>Staffing includes;</p> <p>Registered nurses; there is a registered nurse for every shift Monday to Sunday. The manager and a clinical nurse leader, work six days a week and also provide on call.</p> <p>Care staff</p> <p>Hospital (15 hospital residents) AM; One caregiver on full shifts and one caregiver on half shift, PM; one caregiver on full shifts and one caregiver on half shift. There was one caregiver on night shift.</p> <p>Rest home (23 rest home residents); 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 (10 dementia residents – noting they currently only certified for nine); 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>Family members interviewed stated the staffing was adequate. The residents in the dementia unit can either join other residents outside the unit for activities or caregivers assist with activities in the dementia unit (link to 1.3.7.2). Caregivers in the dementia unit stated they are well staffed and are able to provide activities for residents. Staffing for the dementia unit and for the service overall has been identified as a shortfall, this was a shortfall from the previous certification, but not the previous surveillance audit (for which staffing had been improved).</p>

<p><b>Standard 1.3.1: Entry To Services</b></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>	FA	<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. Residents reported that the admission agreements were discussed with them in detail by the manager. Two dementia resident files reviewed included a copy of the needs assessments and a designated EPOA, this is an improvement from the previous audit.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service has implemented an electronic medication process since the previous audit. Staff have received training and a competency for the new process. Medication reconciliation of monthly medication 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. Care staff interviewed could describe their role regarding medicine administration. Medications were stored safely in the rest home and hospital. The dementia unit medication trolley was locked, but stored in the corridor and the medication keys held by the cleaner.</p> <p>There were no residents self-medicating.</p> <p>Ten medication charts were reviewed on the electronic system. All medications had photographs and allergies documented, but not documented they had been reviewed at least three-monthly by the GP. All medication had been signed for by the prescriber, all as needed medication included an indication for use, all short course medications included a stop date and all eye drops had been dated on opening, this is an improvement from the previous audit. Not all medication not given included a reason.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of</p>	FA	<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</p>

service delivery.		<p>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. 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 service delivery.</p>	PA Moderate	<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. The long-term and short-term care plans reviewed did not all include support required to meet the resident's goals and needs, this is a continued finding.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA High	<p>The service is introducing computer-based care planning and are using a combination of both as the transition is in its infancy (since February), and not all interventions have been fully documented (link 1.3.5.2). The process includes the wound care plans and not all aspects of wound care planning has been fully documented, this is a continued shortfall from the previous audit.</p> <p>There were three 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 which had healed at the time of audit. This residents repositioning was not always documented, and the pressure mattress was set incorrectly.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available one day a week.</p> <p>Monitoring records were sighted; however, repositioning, checking and behavioural 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</p>	PA Low	<p>The service employs two diversional therapists across five days a week with activities led by the caregivers over the weekend. The diversional therapist interviewed displayed an understanding of requirements. All activities are supported by caregivers.</p> <p>The service has one activity plan for rest home, hospital and dementia, weekly activities are posted on a large whiteboard in the main hallway and on resident noticeboards in each area. Activities include outings, baking,</p>

requirements are appropriate to their needs, age, culture, and the setting of the service.		<p>table tennis, bowls, bingo, church services and quizzes. The dementia unit residents are able to join in any of the activities, and were observed to do so, but there is no dementia specific activity plan, or 24-hour activities plans for dementia residents. This is a continued shortfall from the previous audit.</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 reviews. 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. One dementia relative suggested that dementia specific activities could be an improvement.</p>
<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 had been evaluated by registered nurses for long-term residents who had been at the service six months and longer. Written evaluations for long-term residents describe the resident's progress against the residents identified goals. Not all 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 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 shortfall from the previous audit. The dementia unit had a strong malodour and has no hot water in the dining room.</p> <p>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 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 bed.</p> <p>One hospital section of five bedrooms and a lounge was closed for extensive refurbishment at the time of audit.</p> <p>The service has a maintenance schedule in place around equipment. There is appropriate equipment available at the service. All equipment was included in a preventative maintenance schedule. Staff interviewed stated</p>

		<p>there was enough equipment available and equipment is replaced as needed.</p> <p>This audit also reviewed the dementia unit for capacity for a further bed (from nine to ten beds). The service has an email from the DHB approving the use of the tenth room and a respite resident was occupying the room on the day of audit. There was no notification to the ministry of health for a tenth bed at the time of audit. The additional bedroom is fit for purpose as it is a bedroom, however the room has been used at the nurse's station. This has meant that the computer, phone, any nursing notes and medication trolley (locked) were stored in the foyer at the time of audit. There was no designated staff space to discuss residents in privacy. The dining room has space for only nine chairs, and the lounge has only eight easy chairs with no room for further chairs. For these reasons, the dementia unit has not been verified as suitable for 20 beds.</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>	FA	<p>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 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 is 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 (four bedrails and three lap belts) and none in the dementia unit. There were two residents using an enabler. Two resident files reviewed; one for an enabler and one for restraint had all appropriate assessments and reviews in place. Staff training has been provided around restraint minimisation and challenging behaviour (link to 1.3.6.1).</p> <p>There is documented discussion in the RN meeting that 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)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>The service has a combination of a paper-based and computer-based complaints logging. All new complaints since February are logged onto the computer-based complaints log. The two complaints logged onto the complaints log includes written and verbal complaints, dates and actions taken, and demonstrates that complaints are being managed in a timely manner.</p> <p>Complaints received prior to February were paper-based and did not all document responses to complainants, and not all complaints were able to be retrieved on the days of audit.</p>	<p>(i) Two complaints received during November 2018 have no documented response to complainants. (ii) One complaint from district nursing and received via the DHB following the previous unannounced audit, was not able to be located by the service.</p>	<p>(i). Ensure that all complaints are followed up according to right ten of the Code of Rights. (ii) Ensure that complaint documentation is retrievable.</p> <p>90 days</p>

Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA High	<p>There is a roster in place for each of the wings (rest home, hospital and dementia services). The service has a staffing policy and a process to measure staffing levels against a staffing tool. However, the staffing was identified as an area for concern on the days of audit, specifically for the hospital and the dementia wings. On the first day of audit, following a van trip for dementia residents, one caregiver was managing a resident who refused to go back in to the unit, and the other was attempting to assist and encourage eight other residents off the van and into the unit. There was no staff member in the unit to 'receive' the residents back. On the second day of audit the auditor arrived in the dementia unit to find both caregivers locked in the dining room (away from the residents) and only the cleaner with residents (who was also attending to her own duties). The cleaner also held the medication keys (link to 1.3.12.1). The staff advise that the RN is available to assist, but on the two days of audit clinical supervision was not evidenced, and on investigation not specifically planned.</p> <p>Caregiver staffing in the hospital has one long shift and one-half shift for the AM and PM, and one caregiver at night. The rest home has the same roster. This leaves one caregiver in each of the units from 2 pm to 3pm, and 8 pm to the following morning each day. Which does not allow sufficient staff to assist in the dementia unit if needed (which is a separate building), and does allow enough staff for the hospital level residents who are two-person assist. It was also noted that a resident in the rest home (who was in the process of being re-assessed for dementia level care) was very high needs for the staff with no additional staffing in place.</p>	<p>(i) The residents in the dementia unit were not observed to be safely supervised during the audit.</p> <p>(ii) There is a lack of clinical supervision in the dementia unit.</p> <p>(iii) The caregiving staffing is not always appropriate for the level of need and the layout of the service.</p>	<p>(i) Ensure that the residents in the dementia unit are always supervised.</p> <p>(ii) Ensure there is an implemented and documented process for clinical supervision in the dementia unit.</p> <p>(iii) Ensure that there are appropriate staffing taking into account the level of need and the layout of the service.</p> <p>7 days</p>
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe	PA Moderate	There are policies and procedures in place to safely guide staff and to manage the medication process. The medication round observed evidenced good practice by the RN when administering medications. All medication in the medication charts had been verified (electronically signed) by the GP, but not all documented a three-monthly medication review. The dementia unit cleaner was observed to hold the medication keys. Not all medication	i) Three of ten medication charts reviewed had not been reviewed by the GP in the last three months.	(i) Ensure medication charts are reviewed by the GP at least three monthly.

and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		documented the reason it was not administered.	<p>ii) Two of ten charts reviewed did not document the reason a medication had not been administered.</p> <p>iii) The medication keys were held by the cleaner in the dementia unit.</p>	<p>ii) Ensure the medication charts document the reason a medication had not been administered.</p> <p>iii) Ensure medication keys are held by medication competent staff.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	PA Moderate	The service has four interRAI trained registered nurses (two were on extended leave at the time of audit). 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 timeframes and new long-term care plans were not always documented within timeframes. This is a continued shortfall from the previous audit.	<p>i) One of two dementia resident's interRAI and long-term care plan were not documented within 21 days.</p> <p>ii) One of one rest home resident files reviewed did not have the interRAI and long-term care plan within 21 days.</p>	<p>i)-ii) Ensure that the interRAI assessment and long-term care plans are documented within set timeframes.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support</p>	PA Moderate	Care plans are in place for all residents. Staff informed that they are easy to follow and understand. Although a significant improvement was seen since the previous audit, the care plans did not reflect all resident needs. This is a continued finding from the previous two audits.	(i). One hospital resident did not have a short-term care plan in place or the LTCP updated	Ensure that all care plans have documented interventions

and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.			<p>for an eye infection. The long-term care plan did not include interventions around showering and the use of a specialist chair.</p> <p>(ii) One rest home resident did not have interventions in the care plan to manage behaviours that challenge.</p> <p>(iii) One hospital level resident's long-term care plan had not been updated to reflect the change of need following a hospital admission, including nursing interventions for pain management following a hip replacement.</p>	<p>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,</p>	PA High	<p>The families interviewed were positive about the care provided at Kaikohe care centre. RNs are caregivers were able to describe the care needs and monitoring for residents. However, this was not always documented or observed to be provided.</p> <p>The service is in the process of introducing an electronic care planning system and wound care plans are included in the process. The wound care plans had not been fully integrated into the system at the time of audit. Wound care plans did not include all interventions to manage the wound, there were evaluations in place for each of the three wounds and the pressure injury was</p>	<p>(i). One hospital resident's two-hour turns were not documented as occurring. This same resident was nursed on a specialist air mattress; however, the mattress was set</p>	<p>(i). Ensure that resident monitoring is completed, and care provided and documented according to the care plan and assessed</p>

and desired outcomes.		healed on the day of audit. One resident did not have a care plan in place for a toe infection and dressing. Wound care was identified as a high risk finding at the previous audit, so has been identified as a continued high risk.	<p>on 'hard' and at an incorrect weight setting for the resident. This resident had a bedrail insitu which was documented as discontinued.</p> <p>(ii) Wound care plans were evaluated and recorded the care provided, but did not include an assessment and management plan. One dementia resident did not have a wound care plan in place for an identified wound.</p> <p>(iii) One rest home resident did not have behaviour monitoring and checks documented as per care plan.</p>	<p>needs.</p> <p>(ii) Ensure that wound management plans are in place and implemented for all identified wounds.</p> <p>(iii) Ensure that required behaviour monitoring and checks are documented as occurring.</p> <p>7 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources,</p>	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. This is a continued shortfall from the previous audit. There is an activity plan in place for the service, but no specific activity plan in place for the dementia unit.	<p>(i). Two of two dementia unit residents care plans did not document a 24-hour approach to activities.</p> <p>(ii). There was no</p>	<p>(i). Ensure that dementia residents have a 24-hour activity plan documented.</p> <p>(ii). Ensure</p>

and interests) that are meaningful to the consumer.			group activity plan for the residents in the dementia unit.	there is a dementia specific activity plan.  60 days
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA</p> <p>Moderate</p>	<p>The environment was warm, and the main rest home and hospital was very clean. The dementia unit had a malodour. The service is in the process of significant refurbishment. There continues a number of maintenance issues that needs to be addressed.</p>	<p>(i). The environment has areas that require repair, including peeling wallpaper, painting chipped and peeling, a cracked sink in the dementia unit. (ii) The dementia unit had a strong smell of urine. (iii) The dementia dining room has no hot water.</p>	<p>(i). Ensure all reactive maintenance issues are addressed. (ii). Ensure the dementia unit has a fresh and clean odour. (iii). Ensure that hot water is available on the dining areas.</p> <p>60 days</p>

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

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

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

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

No data to display
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End of the report.