

Lexhill Limited - Kaikohe Care

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 BSI Group New Zealand Ltd, 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

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 April 2021 End date: 15 April 2021

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: 53

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Kaikohe Care Centre is certified to provide rest home, hospital (geriatric and medical) and dementia levels of care for up to 59 residents. On the day of the audit there were 53 residents living at the facility. An experienced temporary facility manager, who is a registered nurse, manages the service. Residents and family interviewed were complimentary of the staff.

This surveillance audit was conducted against a sub-set 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 where relevant, the review of residents and staff files, observations and interviews with residents, relatives, the manager, and staff.

The service has addressed three of the five shortfalls identified at their last partial provisional audit around chemicals and the environment. Improvements continue to be required around activities, and food service.

The service has addressed two of three shortfalls identified at their previous certification audit around corrective actions and training. Improvements continue to be required around the activity programme.

This surveillance audit identified further shortfalls around completion of performance appraisals, care planning for a respite resident, evaluation of care plans, completion of neurological observations as required, and infection control programme.

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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Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented, and a complaint register maintained. Complaints were described as being able to be responded to in a timely manner.

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 temporary facility manager is responsible for the day-to-day operations. A quality programme is documented, and this includes management of complaints, implementation of an internal audit schedule, satisfaction surveys, analysis of incidents and accidents, and a health and safety programme.

Residents receive appropriate services from suitably qualified staff. Recruitment is managed in accordance with good employment practice as per documented policies. A comprehensive orientation programme is in place for new staff. Ongoing education and training include in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week. Staff in the dementia unit have completed relevant training around dementia. Rosters and interviews with staff, residents and family indicate that there are sufficient staff that are appropriately skilled, with flexibility of staffing around clients' needs.

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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The registered nursing staff are responsible for each stage of service provision. The assessments and long-term care plans are developed in consultation with the resident/family/whānau.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess care needs of the residents. The residents' needs, outcomes/goals are identified in the long-term nursing care plans.

There is a planned activity programme for the rest home, hospital, and dementia unit. The programme is implemented in the rest home and hospital.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. The medication charts are reviewed at least three-monthly.

Food services and all meals are prepared on site. Resident's individual food preferences and dislikes are known by kitchen staff. Choices are available and are provided, with nutritious snacks being provided 24 hours per day.

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 building has a building warrant of fitness. Equipment is tested and tagged annually with medical equipment calibrated in a timely manner.

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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Staff receive regular education and training on restraint minimisation. One resident was using bedrails as a restraint and no residents were using enablers during the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		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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There is a suite of infection control policies and guidelines to support practice. The infection control coordinator (registered nurse) is responsible for the surveillance programme. The infection control coordinator is responsible for the collation of infections and orientation and education for staff.

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	7	0	5	4	0	0
Criteria	0	31	0	5	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints, are available at the entrance to the facility.</p> <p>Information about the complaints process is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process.</p> <p>The temporary facility manager and 10 staff were interviewed as part of the audit including three health care assistants (HCA), four registered nurses, the diversional therapist, cleaner and cook). The facility manager described their oversight and role in responding to each complaint. Staff interviewed could describe the process around reporting complaints.</p> <p>A complaints register is maintained. Complaints are acknowledged, investigated, and signed off as evidenced on the complaints register. Six complaints were lodged in 2020 and there have not been any in 2021 (year-to-date). Two complaints from 2020 were reviewed. All had been responded in in timeframes as per policy and both had confirmation that resolution of the complaint had been satisfactory to the complainant. There have not been any complaints lodged with an external party since the last audit.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. Regular contact is maintained with families including when an incident or care/health issues arises, as evidenced in the 16 accident/incident forms that were randomly selected for review.</p> <p>Residents (four from the rest home and two receiving hospital level of care) and two family members (one from a resident in the dementia unit and one with family in the hospital) were interviewed. Interviews with families confirmed that they are kept informed. The information pack is available in large print and can be read to residents. Residents also confirmed that they had been kept informed of any changes in the service.</p> <p>Interpreter services are available through the DHB if required. The temporary facility manager reported that this has not been necessary. There were no residents at the facility who did not speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	PA Low	<p>Kaikohe Care Centre provides rest home, hospital (geriatric and medical) and dementia levels of care for up to 58 residents. This includes 30 dual-purpose rooms (hospital or rest home), 19 rest home beds, and 10 dementia beds. On the day of the audit there were 53 residents in the care centre (18 at rest home level including one requiring respite level care, 25 at hospital level including one requiring respite level of care, and 10 at dementia level including one resident who has been moved in the hospital wing after review by the general practitioner (the needs assessment to review level of care has been booked). All residents were on the aged residential care contract (ARCC) apart from one resident under an LTS-CHC contract (long term support-chronic health care).</p> <p>There is a temporary facility manager/RN who is responsible for day-to-day operations including operational management and clinical oversight. The temporary facility manager was in the role but left for extraordinary reasons. They are now on a temporary contract until 10 May 2021. The temporary facility manager has over 20 years' experience in aged care and have a post graduate diploma in health science – aged care along with other training and certificates.</p> <p>There is a business strategy and management plan 2021 in place. The previous business plan for 2020 was sighted however there is no evidence of review of the plan prior to documentation of the new plan. The business owner uses the business strategy and management plan to guide development of the service. The quality plan is documented however this has not been reviewed prior to the new 2021 plan being documented.</p> <p>The temporary facility manager has attended a minimum of eight hours annually of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	PA Moderate	<p>The temporary facility manager is responsible for providing oversight of the quality programme and was able to describe the value and detail of the programme. The quality and risk management programme is</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>documented and designed to monitor contractual and standards compliance.</p> <p>A document control system is in place with all quality documents reviewed on an annual basis by area managers. Staff sign to indicate that they have read and understood policies.</p> <p>Data is collected in relation to a variety of quality activities including adverse events, incidents/accidents, infections, restraint, medications, concerns/complaints, and internal audit outcomes. Data is graphed with comments added to the data sheet. There are a range of meetings expected to occur at regular intervals that include the monthly staff and clinical meetings, quality improvement meetings quarterly (noting that these have not been held regularly), and resident meetings at three to six-monthly. Discussion around the data was not able to be sighted in meeting minutes reviewed. Staff interviewed were not able to describe quality data being discussed in meetings.</p> <p>The temporary facility manger completes six monthly internal audits against core standards, restraint, and infection control. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions have been signed off when completed. The shortfall identified at the previous certification related to resolution of corrective actions has been addressed. A previous manager had also added a quality improvement activity quick fix form that ensured that actions could be taken immediately if risks or issues were identified. This was still in use.</p> <p>Annual resident/relative surveys are completed, and the results fed back to participant through newsletters and resident/relative meetings. The 2020 results showed a high level of satisfaction over the rest home and hospital areas.</p> <p>The service has a health and safety programme in place. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. Health and safety is included in the combined quality and staff meetings. All new staff complete a health and safety induction including emergency situations, fire safety and safe moving and handling and there is ongoing online training for all staff annually. Hazard identification forms are implemented. There is a current hazard register in place. All contractors complete an induction to the facility.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by</p>	<p>PA Low</p>	<p>Staff complete an incident/accident form on an electronic database. Immediate actions and an investigation by an RN is documented. The 16 accident/incident forms reviewed indicated that they were completed in their entirety. Neurological observations are expected to be undertaken if there is a suspected injury to the head or if there is an unwitnessed fall.</p> <p>Discussions with the temporary facility manager confirmed their awareness of statutory requirements in</p>

the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		relation to essential notification. This has been completed for five changes to the facility manager role since the previous certification audit. A section 31 alert has been provided to the Ministry of Health for a stage three non-facility acquired pressure injury.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<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 healthcare assistants, two registered nurses and one diversional therapist). Evidence of signed employment contracts and job descriptions were sighted. Annual performance appraisals were not completed for staff who had been employed for over one year. Newly appointed staff have an orientation that is specific to their job duties.</p> <p>The service has a training policy and schedule for in-service education. Attendance rates for education are documented in attendance registers with these also entered on a spreadsheet on line. Attendance is monitored to ensure that staff attend training offered. Training in 2020 has included hand hygiene, chemical safety with those who handle chemicals taking part in the training, cultural safety, and infection control. All staff attend all mandatory training with documented evidence electronically recorded. The shortfall identified at the previous partial provisional audit has been addressed. Staff have had training around infection control in 2020 (link 3.5.1).</p> <p>There are 17 HCAs working in the dementia unit and all have their dementia qualification. There is a minimum of one staff available 24 hours a day with a current CPR/first aid certificate.</p> <p>Competencies for RNs include medication competencies and syringe driver competencies. Three of seven RNs have completed their interRAI qualification and one is currently in training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There are two registered nurses on both the morning and afternoon shifts and one overnight. The temporary facility manager also provides hands on support if required.</p> <p>The rest home / hospital wing has an occupancy of 17 residents including 15 requiring rest home level of care. The wing is staffed with two HCAs in the morning (one long shift and one on a short shift), one HCA on a long shift and a HCA on a three-hour shift in the afternoon, and one HCA overnight.</p> <p>The hospital wing includes 22 residents at hospital level of care, one at rest home level of care and one from the dementia unit who is due to be reassessed for hospital level of care. The wing is staffed with three HCAs in the morning (two long shift and one on a short shift), three HCAs including two on a long shift and one on a short shift in the afternoon, and one HCA overnight.</p>

		<p>The dementia unit is staffed by two HCAs in the morning, two in the afternoon and one overnight.</p> <p>The reception area is in the centre of the two wings with the nurse's station sited in the hospital wing. The entrance to the dementia unit is near reception and includes an office.</p> <p>RNs interviewed stated that there were sufficient staff on each shift to manage cares required.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. Standing orders were documented and these have been reviewed in December 2020. There are no vaccines stored on site.</p> <p>The facility uses an electronic and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs administer all medications with HCAs deemed competent to support when needed. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the Hospice. The medication fridge temperature is checked weekly, and temperatures are in range. The medication fridge was replaced on the day of audit as the seal had split in the old fridge. This had been identified as requiring repair. Eye drops and other medicines that have a short life span were dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Ten medication charts were reviewed (four rest home, four hospital and two dementia). All evidenced correct signing of the medication chart. Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. 'As required' or PRN medications had indications for use charted with the outcomes of the use of the PRN medication documented in the resident notes.</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>	PA Moderate	<p>The service has a head chef who works Monday-Friday 0600-1430. There are other cooks on duty when the head cook is off duty. There are kitchen hands who work on a rostered system. There are two cleaners who do the entire kitchen cleaning. All cooks have current food safety certificates. The head chef oversees the procurement of the food and management of the kitchen.</p> <p>There is a well-equipped kitchen, and all meals are cooked on site. Meals are served in each area from hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well-presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and</p>

		<p>dislikes. Changes to residents' dietary needs are not always communicated to the kitchen and this is continued shortfall that requires addressing. Special diets and likes and dislikes were noted. The four weekly menu cycle has been approved by a dietitian two years prior to the audit. Snacks are available at all times. All resident/families interviewed were satisfied with the meals.</p> <p>The food control plan was verified on 11 July 2018 as sighted in a previous audit report however the food plan was not able to be checked on the day of audit.</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>	FA	<p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans sampled had interventions documented to meet the needs of the residents and there is documented evidence of care plans being updated as residents' needs changed (link 3.5.1).</p> <p>Resident falls are reported on accident/incident forms and written in the progress notes. Neurological observations are expected to be taken when there is a head 'knock' or for an unwitnessed fall (link 1.2.4.3).</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently six wounds being treated including one pressure injury. The pressure injury is a stage three with the resident having been just admitted from home. It was reported on a section 31. Other wounds are four skin tears and one resident with an auto-immune disease that causes skin to slide off with resulting wounds. These were reviewed through photographs and observation on the day of audit and had improved significantly with support from the RNs. Family were also engaged in care and treatment and were satisfied with care and treatment provided. Photographs are taken of all wounds with comparisons made over time.</p> <p>Monitoring forms and electronic recording are in use as applicable such as weight, vital signs, and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. HCAs document changes of position on turning charts. Some forms are electronic, and some are still paper based.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for</p>	PA Moderate	<p>There are two diversional therapists (DT) both of whom work as a 0.5 full time equivalent (i.e. each works five days a fortnight).</p> <p>There is a weekly programme in large print on notice boards in the rest home, hospital, and dementia unit. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure</p>

<p>a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>activities are meaningful and tailored to residents' needs. These include exercises, bingo, news from the paper, music, quizzes, and games. The programme in the dementia unit is flexible, however the temporary facility manager, DT interviewed, and the RNs noted that activities for residents in the dementia unit occurred mostly when they combined with residents in the rest home/hospital.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There is church service every week. The facility does not have a van, but does hire one occasionally to take residents shopping, for a drive or for a picnic. Special events like birthdays, Easter, Mothers' Day, Anzac Day, and Melbourne Cup are celebrated. Happy hour is fortnightly. There are regular entertainers. There is community input from pre-schools, schools and kapa haka groups.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the resident's past hobbies and present interests, career, and family. Resident files reviewed identified that the individual activity plan is based on this assessment. Dementia residents have 24-hour activity plans. Activity plans are evaluated at least six-monthly.</p> <p>Residents confirmed they enjoyed the activity programme offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Care plans have been reviewed at various times depending on health status. There are some notes made in the evaluation section of the care plan however evaluations of care plans are not completed fully following the six monthly interRAI reassessment. The GP reviews the residents at least three monthly or earlier if required. The multidisciplinary review team includes the nurse manager, RN, caregivers and the resident/relative and any other allied health professional involved in the care of the resident.</p> <p>Short-term care plans for short-term needs were evaluated and signed off as resolved or were added to the long-term care plan as an ongoing problem. Activities plans were in place for each resident, and these are evaluated at the same time as the care plans. Residents and family members interviewed confirmed they are informed of any changes to the care plan</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 20 June 2021. There is a maintenance person who works 37 hours a week. The lawns are mowed by a contractor. Contracted plumbers and electricians are available as required. There is a reactive and preventative maintenance plan.</p> <p>Electrical equipment has been tested and tagged. The hoist and scales are checked annually. HCAs and RNs interviewed, stated they have adequate equipment to safely deliver care. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges,</p>

that are fit for their purpose.		<p>hallways and bedrooms are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. The previous audit shortfall around the decking being a trip hazard and the lack of seating and shade have been addressed.</p> <p>The dementia unit has a large, enclosed garden. There is safe access to all communal areas. The faulty lock to the external gate into the dementia unit was replaced the day after the audit. The shortfall identified at the previous certification related to repairs internally and to the strong smell of urine in the dementia unit have been addressed</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>	PA Moderate	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is expected to be collected and analysed monthly to identify areas for improvement or corrective action requirements. An outbreak of scabies in December 2020 with this ongoing in 2021 has not been recorded effectively with documentation to confirm appropriate management. Infection control internal audits have been completed. Trends are identified by the IC coordinator (registered nurse) who was appointed into the role in November 2020.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers. One resident (hospital level) was using bedrails as a restraint and no residents were using an enabler. Restraint minimisation training for staff is available and includes staff completing a competency questionnaire. These had been completed by staff in the service as sighted on attendance records and in staff files reviewed.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	There is a business strategy and management plan 2021 and a quality plan documented with the previous plans also sighted. The 2020 plans have not been reviewed and there is no change in the goal plan to reflect key areas of concern or areas for improvement. The temporary facility manager states that the business strategy and management plan is used only by the owner and not the service.	(i).The business strategy and management plan 2020 and the quality plan have not been reviewed to show progress against goals documented. (ii). The plans have no relevance to the service as stated by the temporary facility manager.	(i). Review the business strategy and management plan and quality plan prior to development of the current plan. (ii). Provide plans to guide the service around improvement.

				180 days
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Moderate</p>	<p>The service collects and collates quality and risk data however discussion of this is not evident in meeting minutes reviewed. Monthly staff meetings and monthly clinical meetings have been held mostly monthly along with some quality meetings (held in May, June, and September 2020) with health and safety and restraint along with discussion of the data expected to occur. Results of audits and satisfaction surveys are not communicated to staff. Registered nurse meetings do not always reflect discussion of topical issues e.g. the outbreak of scabies. Staff interviewed stated that meetings were not always held at regular intervals and they were not kept well informed. This continues to be an area requiring improvement.</p>	<p>Quality and risk data (e.g. falls, skin tears, results of audits and surveys) is not being discussed at relevant and regular quality and other meetings with evidence of improvements made as a result of the discussions.</p>	<p>Ensure quality and risk data including results of audits and surveys and topical issues are discussed at relevant regular meetings so that areas for improvement can be identified.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>There is a policy around taking of neurological observations if the resident has an unwitnessed fall or a hit to the head. Eleven of the 16 forms reviewed indicated that neurological observations had been taken as per policy.</p>	<p>Five of 16 forms that documented an unwitnessed fall or a hit to the head did not have neurological observations taken as per policy</p>	<p>Ensure that neurological observations are taken as per policy for residents who have an unwitnessed fall or a hit to the head.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p>	<p>PA Low</p>	<p>Five staff files were reviewed. One of the five had a performance appraisal completed annually as per policy. Those outdated were last completed in</p>	<p>Four of the five staff files</p>	<p>Ensure that all staff have a</p>

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.		2019. Training in 2020 has included hand hygiene, chemical safety with those who handle chemicals taking part in the training, cultural safety, and infection control. All staff attend all mandatory training with documented evidence electronically recorded. The shortfall identified at the previous partial provisional audit has been addressed.	reviewed did not have a performance appraisal completed annually as per policy.	performance appraisal completed annually as per policy. 90 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Moderate	The food control plan was verified on 11 July 2018 as sighted in a previous audit report. The food plan was not able to be checked on the day of audit. The last partial provisional audit identified that dietary profiles in the kitchen are not updated six monthly or as changes are identified. This audit identified that the kitchen staff are provided with a dietary assessment for each resident. This is reviewed six-monthly. However, staff in the kitchen stated that they are not informed of any resident who is losing weight and therefore do not alter diets for any residents. RNs manage any products used for residents to support weight gain e.g. addition of Ensure with this noted in the residents' care plan. The previous audit also identified the electric stove was not functioning adequately. This has since been addressed.	(i). The food control plan was not able to be sighted on the day of audit. (ii). Kitchen staff are not kept informed of residents who are losing weight	(i). Ensure that the food control plan is current. (ii). Ensure RNs keep kitchen staff informed of residents who are losing weight with interventions to support weight gain to be put in place 30 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	The RNs interviewed were able to describe timeframes for documentation of assessments, care plans and evaluation of care. Four of the five files reviewed showed that assessments and care plans were documented in a timely manner. One resident in the rest home was on respite level of care and initial assessments and an initial plan had been completed. The resident had been in the care centre for over six months and further assessments, a care plan and evaluation of care had not been completed.	A reassessment, evaluation of care and a revised care plan has not been completed for a resident in the rest home who has been in respite care for over six months.	Complete a reassessment, evaluation of care and a revised care plan for a resident in the rest home who has been in respite care for over six

				months. 30 days
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Moderate</p>	<p>There is a programme documented for the rest home and hospital residents and a separate one for the dementia unit. Staff interviewed stated that there were few activities actually provided by the activities team in the dementia unit. Both the DT interviewed, and care staff stated that they try and provide activities to residents as much as possible. Residents are brought out of the dementia unit to engage with residents in the rest home and hospital for activities whenever possible. Activities were not sighted in the dementia unit on days of audit.</p>	<p>The activity plan in the dementia unit is not well implemented. This continues to be an area requiring improvement.</p>	<p>Implement an activity plan in the dementia unit specifically for those residents in the unit.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>The E system has a space to record the evaluation of the care plan prior to documentation of the revised plan. This had not been completed fully in four of four long term files reviewed noting that some notes are made.</p>	<p>The registered nurse completing a review of the care plan does not document an evaluation of the previous plan prior to formulating the revised plan.</p>	<p>Document an evaluation of the previous care plan prior to formulating the revised care plan</p> <p>180 days</p>
<p>Criterion 3.5.1</p> <p>The organisation, through its infection control committee/infection control expert, determines the type of surveillance required</p>	<p>PA Moderate</p>	<p>A resident was identified as having scabies in December 2020. The resident was treated. Since that date, there have been a further five residents identified as having a rash and symptoms of scabies with the doctor prescribing medication to treat each resident. Family have been informed that their family member has scabies. A log of the cases was documented. One resident file was reviewed as part of the sample selected for audit and a further two were reviewed specifically to review management of scabies. There are gaps in management of the scabies</p>	<p>The IC coordinator was not aware that there was a policy around management of scabies and had not read the</p>	<p>i) Provide training for IC coordinator around policies and procedures related to infection</p>

<p>and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p>		<p>outbreak.</p> <p>Staff have had training around infection control in 2020 however training around management of scabies has not been provided. Staff interviewed were not aware of who was being treated for scabies and were not able to explain management of scabies.</p> <p>On the day of the audit, the district health board portfolio manager phoned for a different discussion but was informed on the day of the current gaps in management of scabies. The temporary facility manager contacted the nurse specialist at the DHB at that point for support.</p>	<p>policy.</p> <p>A plan to manage the outbreak has not been documented.</p> <p>External providers have not been notified of the outbreak apart from the GP who has been involved in treating each resident.</p> <p>Progress notes in three of the resident records who have been identified as being treated for scabies do not document if the treatment has been effective of effective management of symptoms.</p> <p>Staff have not had training around management of scabies.</p>	<p>control and in particular to outbreak management.</p> <p>ii) Document a plan to manage the outbreak of scabies.</p> <p>iii) Maintain contact with external providers both to notify them of any outbreak and to receive advice and guidance on management.</p> <p>iv) Document if the treatment has been effective in management of scabies for those treated and document effective management of symptoms.</p> <p>v) Provide</p>
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				<p>e training for staff around management of scabies and outbreak management.</p> <p>60 days</p>
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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.