

Kapiti Retirement Trust - Sevenoaks Lodge

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

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

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

The specifics of this audit included:

Legal entity: Kapiti Retirement Trust

Premises audited: Sevenoaks Lodge

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: 22 August 2018 End date: 23 August 2018

Proposed changes to current services (if any): This unannounced surveillance audit included review of four beds in the hospital wings of The Lodge. These have been re-designated from hospital to dual use beds so that residents can receive rest home level care in these rooms (Refer letter from HealthCERT 15 February 2018).

Total beds occupied across all premises included in the audit on the first day of the audit: 55



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
Yellow	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
Red	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

Kapiti Retirement Trust provides hospital, dementia and rest home level care for up to 59 residents at The Lodge aged care facility in Paraparaumu on the Kapiti Coast. The facility is part of an extensive retirement village community known as Sevenoaks and Midland Gardens. The Trust is run by a chief executive officer (CEO) who has responsibility for all services on the site.

The aged care facility is managed by a Group Manager Resident Wellness and a team of three clinical managers. Since the previous certification audit, four hospital beds have been changed to dual purpose use, so that residents who require rest home care can be supported at The Lodge. Residents and families spoke positively about the care provided at the facility.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the Capital and Coast District Health Board (C&CDHB). The audit process included review of policies and procedures, review of residents and staff files, observations and interviews with residents, families, management, staff, and a general practitioner.

This audit has resulted in one area requiring improvement relating to the use of enablers.

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The mission and values of the organisation are documented in plans, communicated to residents, families and staff and on display throughout the facility. There are quality and risk management plans and procedures which guide related activities. Monitoring of service delivery occurs regularly and is reported to the CEO and Trust Board.

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

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

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.		Standards applicable to this service fully attained.
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Residents' of Kapiti Retirement Trust (Sevenoaks Lodge) have their needs assessed on admission, within the required timeframes. Verbal handovers and communication sheets guide the passing on of information between shifts and enables continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

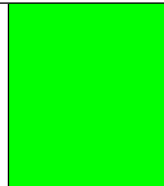
The planned activity programme is overseen by three diversional therapists, a recreational assistant and is assisted by volunteers. The programme provides residents with a variety of individual and group activities and maintains their links with the community. Facility vans are available for outings.

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with the required food safety training, as verified in their approved Food Control Plan. The kitchen was well organised, clean and meets food safety standards. Residents verified a high level of satisfaction with meals.

Safe and appropriate environment

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



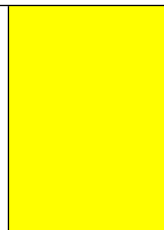
Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness.

Four hospital rooms have been re-designated to dual use so that residents who require rest home level can be supported at The Lodge. They are fit for purpose.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Some standards applicable to this service partially attained and of low risk.

There are policies and procedures available on the safe use of restraints and enablers. The use of enablers is described as being voluntary and systems are available for this to occur.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, data is analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	0	0	0
Criteria	0	40	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The group manager resident wellness manages complaints and demonstrated an understanding of the Code of Health and Disability Services Consumers Rights (the Code). The organisation's policy on complaints/concerns/issues includes a form used for reporting which also meets the requirements of the Code.</p> <p>The complaints register reviewed showed that seven complaints have been received since the beginning of 2018 and that actions taken, through to an agreed resolution, were documented and completed within the required timeframes. Any required follow up and improvements have been made where possible. Communication with complainants is respectful. Staff interviewed confirmed an understanding of the complaint process and what actions are required. A complaints register is maintained which includes the actions taken and status of complaints.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. All residents have instructions on their files which guide staff on when and how their families are to be contacted if this is required. File sampling confirmed that contact instructions were followed, open disclosure was practiced, and one to one, and written communication was respectful.</p>

<p>provide an environment conducive to effective communication.</p>		<p>Staff members interviewed during the audit understood the principles of open disclosure. This is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required. There were no residents who required interpreter services at the time of the audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Kapiti Retirement Trust is governed by a voluntary board of trustees and a CEO. A senior management team report to the CEO and manage the facility. Since the certification audit a new Group Manager Resident Wellness has been appointed. A team of clinical managers who are responsible for each area of the facility report to the group manager. They are clinical managers for dementia, hospital and respite services.</p> <p>The trust has a five-year strategic and business plan (2014 – 2019) which is reviewed annually. In 2017, work was done to review the mission and values for the Trust and these have been refined and are included in documents and on display throughout the facility. The CEO reports to the board each month based on reports from the management team. Copies of these were sighted and confirmed progress against the Trust's plans.</p> <p>Both the CEO and the group manager hold masters of business administration degrees. The group manager is also an experienced registered nurse (RN) with a current practising certificate. She has held senior nursing, policy and management roles, and has been in this role since June 2017. Responsibilities and accountabilities are defined in a job description and individual employment agreement. She demonstrated her knowledge of the sector, regulatory and reporting requirements during the audit and maintains currency through attendance at meetings and relevant available training opportunities.</p> <p>In addition to their contracts for the provision of age related residential care, the service holds contracts with CCDHB for the provision of up to seven respite beds for the Wellington region which are guaranteed at hospital level care, day respite services from 9 am to 3 pm, Monday to Friday; and continuing care which includes end of life care. They also hold a contract with the Ministry of Health for people who are under 65 and require residential care.</p> <p>On the days of the audit there were 55 residents receiving care at Kapiti Retirement Trust. Eleven of the twelve beds in the dementia unit were occupied; 36 of the 37 hospital beds were occupied, three of the four rest home (dual use) beds were occupied, and in the respite unit there were five residents.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	<p>FA</p>	<p>The clinical manager for the dementia unit has responsibility for quality and joined the group manager resident wellness during the interview for quality and risk management systems. The organisation has a planned quality and risk system that is reviewed annually. The current plan (dated 2018) is comprehensive. It includes a wide range of activities, monitoring and reporting to ensure that service delivery meets the requirements of these standards, the providers contracts and residents' needs. The quality and risk activities included management of</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>incidents, accidents, infections, use of restraints and enablers and complaints, internal audit activities, a regular resident and relative satisfaction survey, a staff satisfaction survey, health and safety, risks and hazards.</p> <p>A range of regular meetings are held monthly. These include quality, nursing, pressure injuries, falls, continence, senior healthcare assistance, health and safety and infection control. Other meetings are at different intervals, for example, restraint occurs six monthly, resident meetings are three times a year and a meeting for all staff occurs quarterly. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed. Staff confirmed their involvement in meetings, that quality and risk management activities are discussed, with trends and corrective actions developed and implemented to address any shortfalls.</p> <p>Resident and relative satisfaction surveys are completed annually. The most recent survey showed a 93% overall satisfaction rate with services and care at The Lodge.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The group manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Both managers are familiar with the Health and Safety at Work Act (2015) and its requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Adverse and near miss events are recorded on an accident/incident form. A random selection of events was sampled and showed that these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported at the quality committee, nursing and other relevant meetings, with significant events escalated to the CEO and board.</p> <p>The group manager and the clinical manager - quality described essential notification reporting requirements. Examples of notifications made to the Ministry of Health since the last audit were reviewed with the managers. These included changes to board of trustee members, the group manager's appointment and appropriate adverse event notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	<p>FA</p>	<p>Kapiti Retirement Trust has human resources management policies and processes which are based on good employment practice and relevant legislation. The recruitment process included referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>reviewed confirmed the organisation's policies were being consistently implemented and records were maintained.</p> <p>An orientation programme includes all necessary components relevant to the service and specific roles. Staff reported that their orientation prepared them well for their position. Personnel records reviewed had evidence of completed orientations, and regular appraisals on an annual cycle after the initial three-month introductory period.</p> <p>Continuing education is planned by the clinical manager – respite. A calendar with annual and biennial training is scheduled with sessions identified for nurses, health care assistants, housekeeping, kitchen staff and all staff. Those care staff who have not already completed New Zealand Qualification Authority education programmes to meet the requirements of the provider's agreement with the DHB, are supported to do so. There is a designated staff member who manages this and who is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The clinical manager - hospital services completes the rosters for the aged care facility. Staffing levels are adjusted to meet the changing needs of residents throughout.</p> <p>There is access to managers or senior staff after hours (overnight and at weekends). Staff reported that they have good access to advice, which is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Absences in the healthcare assistant team can be covered from the village wellness team who provide services to retirement village residents and this minimises the use of agency staff. At least one staff member on duty in each area has a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage in The Lodge.</p> <p>The re-designation of the four beds from hospital to dual purpose (rest home care) use has not required any adjustment to the staff rosters. The rooms are spread across The Lodge so that each rest home level resident is amongst hospital level residents and they are accommodated within the existing staffing allocation.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy at Sevenoaks Lodge is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The management of medication at Sevenoaks Lodge has recently been upgraded to include an electronic medicine management system. Residents receiving respite care, where possible are included on the electronic system. Where this is not possible, hard copy medication charts are used in addition to a comprehensive reconciliation process, recognised as an area of continuous improvement at last audit. An initiative is underway at Sevenoaks Lodge to address the logistics of enabling all residents receiving respite care to have their medications recorded electronically, however the project was not completed at the time of audit.</p> <p>A safe system for medicine management using the electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. Electronic acknowledgement of this occurring was sighted. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs were stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's electronically recorded signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administering medications at Sevenoaks Lodge at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN, clinical team manager of each area, and the group manager resident wellness. Errors are recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are used and were consistent with standing order guidelines.</p> <p>No changes are required to the medication management system at Sevenoaks Lodge, because of the reconfiguration of the four beds.</p>
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<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service at Sevenoaks Lodge is provided on site by cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. Sevenoaks Lodge has a food control plan in place. A verification audit of the plan was undertaken in October 2017, with the next audit due to be undertaken in October 2018.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager and the cooks have undertaken training in safe food handling. Kitchen assistants complete relevant food handling training on site, and evidence of this was sighted.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Residents in the secure unit always have access to additional nutritious snacks.</p> <p>Evidence of resident's high level of satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> <p>No changes are required to the food service because of the reconfiguration of the four beds.</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>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with each resident's needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. Residents requiring a palliative approach had access to specialist input and advice. Accidents and incidents were managed promptly, as evidenced by a recent event requiring the resident's transfer to an acute facility. Behaviour management plans are in place for residents in the secure unit. The plan identifies potential behaviours, possible triggers and management strategies to manage these behaviours.</p> <p>Staff were observed providing respectful care in line with assessment findings, residents' need, and in accordance with best practice guidelines. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was</p>

		provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided at Sevenoaks Lodge by three qualified diversional therapists, a recreation assistant and the assistance of 80 volunteers. The programme is provided Monday-Friday and every alternate Saturday. Activities are no longer provided on a Sunday, at the request of families and residents.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, cultural, religious, spiritual and social requirements. A " Life Map" portrait is created for each resident, and visually portrays the resident's values and beliefs, memorable holidays, employment/skills, childhood memories, parents, siblings and other aspects of the resident's life. This enables staff to have some knowledge of the resident's life prior to living at Sevenoaks Lodge. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal three-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include a men's group, crafts groups, walking groups, bowls, housie, energise, nifty nails, visiting entertainers, quiz sessions, one on one sessions and daily news updates. The activities programme is displayed in all common areas and in each resident's room. A facility van and a bus enable residents to attend a range of outings and community events.</p> <p>A specific activities programme operates daily in the secure unit. The programme is provided by one of the diversional therapists. The activities assessment of each resident in the secure unit, identifies a twenty-four-hour approach that includes all aspects of the resident's life and past routines.</p> <p>The activities programme is discussed at the minuted residents' and family meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p> <p>No changes are required to the activities programme because of the reconfiguration of four beds.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN, and passed over to oncoming staff at handover.</p> <p>Formal care plan evaluations occur every three months and six monthly in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress</p>

<p>evaluated in a comprehensive and timely manner.</p>		<p>is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for infections, pain, weight loss and behaviour management and progress was evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed</p> <p>Residents in the secure unit had ongoing evaluation of the effectiveness of behavioural management strategies and monitoring of any medication changes regarding not only its effect on behaviour, but identifying any potential increased risks associated with certain medications. Evidence verified staff in the secure unit were alert to changes in residents' status, that could be indicative of a potential problem when the resident was unable to verbalise.</p> <p>Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 11 November 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Four hospital bedrooms have been re-designated as dual-use so that residents can be supported at rest home level. These rooms were reviewed during this surveillance audit. Three of the rooms were occupied by residents who were receiving rest home level care on the days of the audit.</p> <p>The rooms are appropriately sized for the provision of rest home level care and had the necessary furniture and can accommodate residents' personal items. Residents were interviewed and stated that they were happy with their bedroom, its outlook and the provision of care.</p> <p>The rooms provided safe equipment which was maintained and promoted independence.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and</p>	<p>FA</p>	<p>Surveillance of infections at Sevenoaks Lodge is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control nurse, clinical team manager of each area, and the group manager resident wellness review</p>

<p>methods that have been specified in the infection control programme.</p>		<p>all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings, at staff handovers and on the notice board in the staff room. Surveillance data is submitted to an Australasian Group for benchmarking. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked externally with other similar aged care providers and this is used to improve infection rates.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>Policies and procedures are available on restraint minimisation and safe practice. The use of enablers is included. However, the policy and procedures which guide the use of enablers are limited in the instructions for the review of a resident's ability to consent to their enabler and how to change the status of equipment from enabler to restraint when a resident's ability to consent for themselves changes.</p> <p>The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated an understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>A similar process is followed for the use of enablers as is used for restraints. On the day of audit, six residents were using enablers, which were reported to be used voluntarily at their request. However, consent forms were signed by the residents in only two of the six residents' files. On the other four residents' files the enabler consent was signed by the EPOA or a family member with no reason stated as to why this had occurred.</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 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	PA Low	<p>At Kapiti Retirement Trust bed rails and or lap belts in wheelchairs are used as approved enablers. The use of enablers was reported to be voluntary. There is a policy to guide staff in the assessment of residents who request the use of equipment for their safety and wellbeing. This states that residents are to give consent themselves and to sign a document called ‘Information on restraint and enabler use for families / enduring power of attorney’.</p> <p>Six residents were using enablers on the days of the audit. Of these six people, only two have signed their own Information (consent) on Restraint and Enabler use for Families / Enduring Power of Attorney which is on their file. These two residents were interviewed and confirmed that they have consented to the use of their enabler and that they are supported safely to use</p>	<p>On the day of the audit six residents were on the Restraint and Enabler Register with bed rails and / or lap belts, when using a wheelchair, as enablers. The document which is used to record consent is signed by someone other than the resident for four of the six people who were using enablers at the time of this audit. In two cases, staff reported the residents were no longer able to provide consent. In these cases, it was unclear whether these were being used as enablers or restraints. For the other two residents there has been no evidence of a review of their enabler since its initiation.</p> <p>The organisation’s policy and procedure are not detailed enough to guide staff in situations where a resident is not competent to decide/consent or are physically unable to sign.</p>	<p>Ensure that when enablers are used the resident signs the consent, or if they are unable to do so, the form is appropriately annotated. If the person is no longer able to give consent, then the use of the equipment is reviewed and more appropriately assessed as a restraint.</p> <p>Review the policy and procedure to</p>

		<p>their enabler.</p> <p>In the case of the four residents whose form had been signed by someone else (their EPOA or a family member), there is no annotation either on the form or in their notes, to state why the resident has not signed this form themselves. For two of these four people the staff member interviewed stated that these residents were no longer able to give consent themselves. The equipment was now no longer an enabler but was a restraint. The policy and procedure do not provide adequate guidance to staff about how to manage the process in these cases, and the distinction between an enabler and a restraint.</p>		<p>ensure that it provides sufficient guidance for staff members in relation to voluntary use of enablers and when these may become restraints.</p> <p>90 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.