Ruapehu Masonic Association Trust

CURRENT STATUS: 28-Jun-11

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.

GENERAL OVERVIEW

Masonic Court Home has 53 bed capacity and provides rest home level care. There is a documented Philosophy of service. On the day of the audit there were 51 rest home residents. The manager is an enrolled nurse with 24 years management experience in aged care. She is supported for 32 hours per week over four days by an experienced registered nurse. There are job descriptions for both positions that outline responsibilities and accountabilities.

The service continues to implement their quality and risk management system since previous audit.

Some improvements have been made since the previous audit in relation to advanced directives, the complaints register and regular quality and health and safety meetings.

This audit has identified the following improvements required by the service including open disclosure, care planning interventions, and medication documentation.

AUDIT SUMMARY AS AT 28-JUN-11

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights	Day of Audit 28-Jun-11	Assessment
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.		**No short falls**

Organisational Management	Day of Audit 28-Jun-11	Assessment
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 minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity**

Continuum of Service Delivery	Day of Audit 28-Jun-11	Assessment
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.		**A number of shortfalls that require specific action to address**

Safe and Appropriate Environment	Day of Audit 28-Jun-11	Assessment
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.		**No short falls**

Restraint Minimisation and Safe Practice	Day of Audit 28-Jun-11	Assessment
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		**No short falls**

Infection Prevention and Control	Day of Audit 28-Jun-11	Assessment
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.		**No short falls**

Ruapehu Masonic Association Trust

Date of audit: 16-Mar-10 (Certification)

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the (Re)Certification conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.

GENERAL OVERVIEW

Masonic Court Home has 53 bed capacity and provides rest home level care. There is a documented Philosophy of service. The Manager is an enrolled nurse with 23 years management experience in aged care. The service also employs a Registered Nurse who is experienced in community nursing and works 4 days a week.

The Home has a current building certificate . Residents' rooms are of sufficient space and residents are able to access areas for privacy if required. Masonic Court is a spacious, homely facility with a large activities hall and landscaped grounds. Furniture is appropriate to the setting and arranged in a way that enables residents to mobilise.

The Home has a current business and quality management plan 2010/2011. A monthly report is provided to the governing body.

The Home has continued implementing their quality management system since previous certification. There are implemented health and safety policies that include hazard identification. The quality programme is designed to monitor contractual and standard

compliance and the quality of service delivery. The policies and procedures are reviewed regularly and new polices are developed by the management and approved by the Governing body.

There is 1 Diversional therapists who works 38 hours per week; she is a Qualified Divertional Therapist. There is a wide range of activities offered, that reflect the wide range of resident needs and participation is voluntary. The programme is developed a month at a time and is displayed (in large print) in the rest home.

The menu is designed and reviewed bi annually by a Registered Dietician. Diets are modified as required.. Residents interviewed are happy with the quality and quantity of food provided.

The service has in place job descriptions of all positions and staff has employment contracts. Staff orientation programme is well established and includes documentation review (policies and procedures) and observational care monitoring and competences. There is an implemented annual training schedule in place and staff training exceeds 8 hours per annum.

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Staff are qualified/skilled and up to date in their knowledge.

The audit team identified opportunities for improvement around residents care needs assessment, care plan development and evaluations, medication reviews, chemical management, review of use of enablers, review of advanced directives, staffing level and maintenance of complaint register.

SUMMARY

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service attained with some criteria exceeded
	No short falls	Standards applicable to this service attained with all criteria achieved
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Standards applicable to this service attained but with some criteria partially achieved and of negligible or low risk
	A number of shortfalls that require specific action to address	Standards applicable to this service attained but with some criteria partially achieved and of medium, high or critical risk and/or some criteria unattained

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained

Consumer Rights	Indicator	Assessment
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		**Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity**

Organisational Management	Indicator	Assessment
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 minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity**

Continuum of Service Delivery	Indicator	Assessment
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.		**A number of shortfalls that require specific action to address**

Safe and Appropriate Environment	Indicator	Assessment
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.		**A number of shortfalls that require specific action to address**

Restraint Minimisation and Safe Practice	Indicator	Assessment
Includes 3 standards with outcomes where: • Consumers receive and experience services in the least restrictive manner through restraint minimisation • Consumers requiring restraint receive services in a safe manner • Consumers requiring seclusion receive services in the least restrictive manner		**A number of shortfalls that require specific action to address**

Infection Prevention and Control	Indicator	Assessment
Includes 6 standards which require: • There is a managed environment, which minimises the risk of infection to consumers, service providers and visitors appropriate to the size and scope of the service. • There are adequate human, physical and information resources to implement the infection control programme and meet the needs of the organisation. • Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislation requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe and appropriate/suitable for the type of service provided. • The organisation provides relevant education on infection control to all service providers, support staff and consumers. • Surveillance for infection is carried out in accordance with agreed objectives, priorities and methods that have been specified in the infection control programme. • Acute care and surgical hospitals will have established and implemented policies and procedures for the use of antibiotics to promote the appropriate prudent prescribing in line with accepted guidelines. The service can seek guidance from clinical microbiologists or infectious disease physicians.		**Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity**

AUDIT RESULTS

Consumer Rights

The Code of Health and Disability Consumer's Rights is made available in appropriate formats. Residents and their families/whanau are informed of their right to complain and access an advocate. The service has an information pack which contains all relative information about the code. The information is printed in a large font if required and can be read to the residents. The code of rights is included in the staff orientation programme and staff receives training 2 yearly.

There is a 'Recognition of Individual values and Beliefs' policy. All rooms are single and Masonic Court has several small lounges to enable residents to have private discussion. . All staff and volunteers signs confidentiality agreement. Information held electronically is protected by password and it is only accessible to relevant staff.

A Maori Health Plan and policies are in place to support Maori residents and whanau. The policies for Maori identify the importance of whanau. The Home has a Kaumatua who directly consults the service, and his contact details available for staff to contact him as needed.

The service gathers information related to residents cultural and individual beliefs on the admission however resident files reviewed lack evidence of interventions to guide staff to respond resident's cultural needs. Residents and family members interviewed felt that service providers on the whole identified and responds well to residents belief and value systems. There is a policy on links with family and other community resources. Resident are encouraged to maintain contact with the community.

There are policies and procedures in place to ensure that residents are not subject to discrimination, coercion, harassment, and sexual and other exploitation. Staff signs confidentiality statement as part of the employment contract. Job descriptions includes key performance areas and expected outcomes.

The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Residents and Families spoke positively about the care provided.

There is an open disclosure policy which is currently under review by the Trust Board. Resident meetings occur regularly and the Management team has an open-door policy. Resident and families interviewed confirmed that they can identify staff members easily as the service has a very low staff turnover and staff wear a uniform.

There is an informed consent policy. Informed consent agreements are signed and copies are retained in resident files. Policies and procedures clearly direct the service in relation to the gathering of informed consent. There is a advanced directives policy requires staff training at least 2 yearly which is not undertaken in last 3 years. The policy also requires review of current advanced directives at least yearly but this does not occur.

The serviced advised that residents have access to visitors of their choice and guides ensuring residents safety and comfort is maintained.

There is a concerns, compliments and complaints policy which complies with right 10 of the Code. The complaint process is in a format that is readily understood and accessible to residents/family/whanau this is included at the entry to the service. Residents/family/whanau is supported to discuss the complaint process. Written complaints are recorded in the complaint and concerns folder but a register is not initiated. Verbal complaints and resolution of the complaint are not recorded.

Organisational Management

Masonic Court Home has 53 bed capacity and provides rest home level care. There is a documented Philosophy of service. The Manager is an enrolled nurse with 23 years management experience in aged care. She maintains her current practicing certificate. She conducts internal training for her staff. The service also employs a Registered Nurse who is experienced in community nursing and works 4 days a week (30 hours a week).

In the absence of the manager, the registered nurses and the office administrator fulfil the manager's role.

The service has a current business and quality management plan 2010/2011. A monthly reports are provided to the governing body.

The service has continued implementing their quality management system since previous certification. There are implemented health and safety policies that include hazard identification. Service appropriate management systems, policies, procedures, codes of practice and guidelines are implemented and maintained. The quality programme is designed to monitor contractual and standard compliance and the quality of service delivery. The policies and procedures are reviewed regularly and new polices are developed by the management and approved by the Governing body.

The service collects information on accidents, and incidents. Individual incidents are reviewed by the manager and the RN. Analysis of incidents occurs. These results are reported to staff and board meetings. Discussions with the manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an opportunity for the service ensure that H&S meeting occurs regularly and all analysis of data includes action plans where appropriate are identified, implemented and signed off.

Open disclosure is provided by the service through the incidents/accidents process. Family contact is documented in progress notes. Relative interviews confirmed that they are informed of adverse events. Caregivers interviewed stated that relatives are contacted.

The service has in place job descriptions of all positions and staff has employment contracts. Job descriptions includes key performance areas and expected outcomes. The service has in place a qualification verification process and includes checking of referees. Job applicants are required to disclose any criminal convictions and police checks are completed for the staff recently employed. Staff orientation programme is well established and includes documentation review (policies and procedures) and observational care monitoring and competences. There is an implemented annual training schedule in place and staff training exceeds 8 hours per annum.

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Staff are qualified/skilled and up to date in their knowledge. .There is staff on duty to match needs of different shifts but there is only 1 caregiver is available to attend resident's care between 1.30 to 3.30pm. On the audit day, it is observed that residents are required to wait for staff to attend their needs.

The service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information gathered at admission/entry with the involvement of the family. There are resident files in use appropriate to the service. However there is an opportunity for the service to ensure that resident's records are accessible to all relevant staff.

Continuum of Service Delivery

The service conducts an assessment of needs on entry of a resident to the service. This includes identification of risks. Residents and family members confirm/sign off that an assessment process is completed and this is to identify needs and associated risks. There is a need to assess resident for pain and behaviour where indicated and to conduct assessments on residents on respite.

The reason for declining service entry to residents is recorded should this occur and communicated to the resident/family/whānau. An initial care plan is completed within 24 hrs of admission and the long term Lifestyle Plan is completed within 3 weeks by the R.N's with input from Care staff. Evaluations and reviews are to occur 6 monthly or when health status changes (this does not always occur). Residents and family (where appropriate) are involved from time of admission and continue to be involved when there is a review of the care plan. Communication with family is documented. There is a Short-term care plan that is well used. The personal needs information is gathered during admission to form the basis of the lifestyle plan; plans are goal oriented. Assessments are conducted in an appropriate and private manner. Assessments and support plans include input from allied health. Families and residents interviewed are very supportive of the care provided. There are policies that support service delivery plans, care plans are individualised. There are medical notes and evidence of visits from allied health professionals. Residents where possible retain the services of their own Doctor; there is evidence of referrals to specialist services. The facility has R.N's on call a record of all health practitioners practicing certificates are kept. During the tour of facility it was noted that all staff treated residents with respect and dignity. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The referral is co-ordinated by the RN. Referral Policy clearly outline the process and cooperation during referral.

There is 1 Diversional therapist who works 38 hours per week; she is a Qualified D.T. On or soon after admission, a social history is taken and information from this is fed into the Lifestyle plan. Spiritual and cultural preferences are also identified. A section on recreation is part of the long-term plan for the resident and this is reviewed 6 monthly as part of the Lifestyle plan review. A record is kept individual residents activities. There are monthly recreational progress notes in the resident's file. The resident/family/whanau as appropriate is involved in the development of the Activity Social profile and plan. There is a wide range of activities offered, that reflect the wide range of resident needs and participation is voluntary. The programme is developed a month at a time and is displayed (in large print) in the rest home.

The service uses 4 weekly Medico/Douglas packs. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Webster pack medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are kept in a locked cupboards in a locked dispensary. There are G.P. approved standing order medications. Staff sign for the administration of medications. There is a list of specimen signatures and competencies which are conducted annually or if a staff related medication error occurs, there is a need to ensure the competencies are conducted by a Registered Nurse. There is a locked safe and Controlled Drug Register. These drugs are checked on arrival and on dispensing. Controlled drugs are checked by the Pharmacist and R.N. on arrival. There is a comprehensive medication manual with policies for each stage of medication management including policy on self medication Allergies are recorded on the drug chart and there are adverse reaction policy and protocols.

Informed that the R.N. is contacted for approval to give p.r.n. medications. There is a need to ensure medications are charted correctly and that all medications have a signing sheet. Food temperatures are monitored on arrival and prior to service. All staff serving food have Food Handling Certificates. The service has a large kitchen that contains a walk-in chiller and pantry and a fridge/freezer; The menu is designed and reviewed bi annually by a Registered Dietician. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented daily. Resident satisfaction survey which includes food are held annually and food is on the agenda of the residents meetings. Residents interviewed are happy with the quality and quantity of food provided. The residents have a Nutritional Profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed 6 monthly. There is a kitchen manual which covers all aspects of safe food management there is also special equipment available as required.

Safe and Appropriate Environment

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. There is an incident reporting system that includes investigation of these types of incidents. Chemicals are labelled but not securely stored. There is appropriate protective equipment and clothing for staff.

Entry and exit points from the building are accessible to disabled persons and appear compliant with relevant legislation. The service has a current building certificate that expires on 22/6/10 and maintenance is carried out. Furniture and fittings are selected with consideration to residents' abilities and functioning. Resident's can and do bring in their own furnishings for their rooms. There is enough room throughout the service for residents to mobilise safely. There are adequate numbers of toilets and showers with access to a hand basin and paper towels. Hot water temperature is monitored at 40- 45 degrees C. Fixtures, fittings and floor and wall surfaces appear to be made of accepted materials for this environment. Communal toilets and showers are well signed and identifiable

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents between rooms is not necessary in the resident's bed and equipment can be transferred between rooms.

The service has in place policies and procedures for effective management of laundry and cleaning practices. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. Chemicals were not stored securely.

The service has implemented policies and procedures for civil defence and other emergencies. There is staff on duty with a current first aid certificate. Fire drills are conducted 6 monthly and the NZFS approved the evacuation scheme on 10/11/1998. Emergency lighting and cooking is available in the event of a power failure. Call bells are in use. Security procedures are established. Residents individual planning identifies additional needs as required.

General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated areas

Restraint Minimisation and Safe Practice

The service has a restraint policy that is applicable to the facility. Assessment processes and care plans are in place to identify risk and avoid the use of restraint. There is a Restraint assessment tool available and has been completed for the 4 residents requesting bedsides/enablers of safety. There are comprehensive policies and procedures in the safe use of these. The process of assessment and evaluation of enabler use is documented. The policy states that the resident will be fully informed regarding the purpose and use of the enabler and will voluntarily agree to its use.However one of the files reviewed revealed that although residents signed the consent form for use of bed side rails, family member interviewed stated that the resident had not voluntarily agree to its use at first place but the family supported the decision of use of bed sides for safety purpose to minimise falls risk. The service should ensure that use of enablers are voluntary.

Infection Prevention and Control

The content and detail of the IC programme is appropriate for the size, complexity, and degree of risk associated with the service. There is a Scope of the IC programme policy and IC programme description. The service has an established and implemented Infection Control programme, which is linked into the Risk Management system. The programmes has been reviewed annually. IC coordinator responsibilities and Job descriptions are in place. The IC committee includes coordinators from all areas of the service. There are I.C. objectives for the committee. Data is collated and analysed on infections monthly. Benchmarking occurs within the organisation. IC meetings occur as part of a combined Quality/IC/H&S meeting and they meet monthly. The Infection Control programme is well established across the organisation and Masonic court. Regular audits are conducted which provides timely feedback to the staff members with infection control responsibilities. There are guidelines and staff health policies. There are policies and guidelines for managing outbreak and pandemic planning. The facility has access to I.C. expertise. Infection Control Programme description includes programme authority and responsibility. Staffs interviewed could describe their responsibilities. There are objectives for the IC Committee. There is an IC 'Coordinator Responsibilities'' and Job Descriptions. The Infection Control Nurse R.N. attends regular I.C. meeting at WDHB and has I.C. training. Staff training around IC is provided to all staff in compulsory in-service. The infection control coordinator/nurse has access to all relevant resident information to undertake surveillance, audits, and investigation. Advised this is undertaken in a confidential manner.

The Infection Control Manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight. There are policies on staff health, outbreak management. I.C. policies are appropriate for the service.

The Infection Control Coordinator is responsible for coordinating/providing education and training to staff (Job Description) including orientation. She has received training through WDHB annually. Compulsory training has occurred in June 2009. and is included in the orientation of new staff programme. Education content, attendance record and evaluations were evidenced.

IC Surveillance Policy describes and outlines the purpose and methodology for the surveillance of infections. The IC coordinator/ Nurse is responsible for ensuring effective

monitoring which includes surveillance and uses the information obtained through surveillance to determine infection control activities. The service submits infection control data to the governing body for the benchmarking programme which analyses the data. All information gained from surveillance is fed back to the I.C. committee and staff. Infection control data is collated monthly. There is a need to include all infections in surveillance