# CHT Healthcare Trust - Malyon Hospital and Rest Home

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** CHT Healthcare Trust

**Premises audited:** Malyon Hospital and Rest Home

**Services audited:** Hospital services - Geriatric services- medical services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 25 February 2015 End date: 26 February 2015

**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:** 32

# 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 |
|  | 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

Malyon House Te Puke is privately owned and operated and cares for up to 33 residents requiring rest home and hospital level care. On the day of the audit there were 32 residents.

This audit was undertaken to establish the level of preparedness of a prospective provider to provide a health and disability service and to assess conformity prior to a facility being purchased.

The audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident’s and staff files, observations and interviews with residents, relatives, staff and management. The current manager is well experienced and qualified for the role and will be remaining in position with the new owners. The new owners, CHT, have 11 other facilities. The organisation has comprehensive policies and procedures with which to guide staff. It is CHT’s intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The organisation has a plan for the transition and change of ownership which will see the implementation of CHT policies and procedures.

This audit has identified areas for improvement around consents, internal audits and admission agreements.

## Consumer rights

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| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of low risk. |

The staff at Malyon House ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints and concerns have been managed and a complaints register is maintained.

## 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 low risk. |

The new owners of Malyon House Te Puke are experienced providers of aged care services. CHT was formed in 1962 and is a charitable trust. The trust board is supported by a chief executive and a finance manager. The organisation has a transition plan in place to facilitate the smooth transition between owners with the least disruption of services for staff and residents which includes the ongoing employment of the current manager. The facility will be overseen by an area manager with implementation of CHT policies and procedures to be rolled out.

Malyon House has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data with recent evidence of benchmarking outcomes with other similar aged care facilities. Corrective actions are identified and implemented. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

## Continuum of service delivery

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| --- | --- | --- |
| 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 low risk. |

Entry to the service is managed primarily by the clinical manager. There is comprehensive service information available. Initial assessments using the InterRAI tool are completed by a registered nurse in addition to other assessments not covered by the InterRAI. Care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. The medicines management system complies with legislative and contractual requirements. General practitioners reviewed residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

## 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 building has a current warrant of fitness and emergency evacuation plan. There is a preventative and planned maintenance schedule in place. Chemicals are stored safely throughout the facility. The majority of bedrooms are single occupancy and most have their own ensuite. One of two double rooms was occupied by two residents. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge areas throughout the facility in addition to its main communal area and dining room. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning, laundry and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There were four residents requiring restraints and three residents using enablers. The service reviews restraint as part of the quality management and staff are trained in restraint minimisation.

## Infection prevention and control

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| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## 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 | 47 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 98 | 0 | 3 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Discussions with staff (three healthcare assistants, two registered nurses, the clinical manager and the activities coordinator) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Six residents (three rest home and three hospital) and two relatives (one rest home and one hospital) were interviewed and confirmed the services being provided are in line with the Code. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | Informed consent processes are discussed with residents and families on admission. Written consents are included in the admission agreement. Advanced directives are signed for separately. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The general practitioner (GP) discusses resuscitation with families/EPOA where the resident was deemed incompetent to make a decision. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives.  One resident did not have a signed admission agreement that includes consents. A review of all admission agreements showed that there were admission agreements including consents in place for the remaining 31 residents. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. The chaplain visits weekly and is able to advocate for residents. Residents’ meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident’s life have been documented in the care plans. Residents and relatives verified that they have been supported and encouraged to remain involved in the community. Entertainers have been invited to perform at the facility. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | A complaints policy and procedures have been implemented and residents and their family/whanau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Four complaints were received in 2014. These were reviewed and show appropriate acknowledgement, investigation and resolution within required timeframes. Systems and processes have been in place to ensure that any complaint received is managed and resolved appropriately. Residents and family members advised that they are aware of the complaints procedure and how to access forms. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well-informed about the code of rights. Resident meetings and a resident and family survey provide the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and are available at the service. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident’s privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment.  Church services are held three times monthly alongside weekly Catholic communion and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy and staff education and training on abuse and neglect has been provided. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service has a Maori heath plan and an individual’s values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. There are currently six residents at Malyon House who identify as Maori. The service has established links with local Maori and staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. The Maori staff and general practitioner (GP) converse with staff in Te Reo and there is an annual Cavell Group Maori Cultural meeting with all Maori staff from across the organisation where relevant issues are discussed. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of house rules and a service code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Registered nursing staff have completed training around professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The clinical manager is responsible for coordinating the internal audit programme. A variety of staff meetings and residents meetings are conducted.  Residents and relatives interviewed spoke very positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the clinical manager. Care staff complete competencies relevant to their practice. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. This is confirmed on incident forms reviewed. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur three monthly and the clinical manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken English the interpreter services are made available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | This provisional audit was conducted to assess the preparedness of new owners for the facility and included an interview with the new area manager, review of the transition plan and interviews with the current facility manager, clinical auditor and care staff. The new owners, CHT, have 10 other facilities. The organisation has comprehensive policies and procedures with which to guide staff. It is CHT’s intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The organisation has a plan for the transition and change of ownership which will see the implementation of CHT policies and procedures.  Malyon Te Puke has been privately owned and operated The service provides care for up to 33 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 32 residents in total (15 residents at rest home level and 17 residents at hospital level). The service has been managed by an experienced clinical manager who has been in the role for 18 years and will continue to manage the facility after the change of ownership. The clinical manager reports to the directors and to the wider Cavill Group on a variety of management issues. The current strategic plan and quality and risk management plans for the Cavill Group have been implemented. The clinical manager receives support from a registered nurse, the administration manager, the directors and care staff. The manager has completed at least eight hours of training related to management of a rest home and hospital in 2014. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The senior registered nurse and administration manager provide cover during a temporary absence of the nurse manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The quality manual and the strategic, quality, risk and management planning procedure describe Malyon House’s quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the clinical, staff and health and safety meetings. Meeting minutes have been maintained and staff were expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with registered nurses and healthcare assistants confirmed their involvement in the quality programme. Resident/relative meetings have been held. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2014 has been partially completed. Areas of non-compliance identified at audits have been actioned for improvement. Benchmarking with other similar Cavill Group facilities occurs. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death. Falls prevention strategies are implemented for individual residents. Residents’ are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for February 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service benchmarks incident data with other similar Cavill Group facilities. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | The recruitment and staff selection process requires that relevant checks have been completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Seven staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 20 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. A completed in-service calendar for 2014 exceeded eight hours annually. The clinical manager and registered nurses attend external training including seminars and education sessions with the local DHB. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Malyon House has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is at least one registered nurse on duty at all times. The full time clinical manager is also a registered nurse. Healthcare assistants and residents and family interviewed advised that sufficient staff are rostered on for each shift. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files are protected from unauthorised access by being locked away in the nurses’ station. Information containing sensitive resident information are not displayed in a way that can be viewed by other residents or members of the public. Record entries are legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. Medication charts have been stored in a separate folder. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | PA Low | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the clinical manager. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored and managed. Medication administration practice complies with the medication management policy. Registered nurses administer medicines and senior caregivers are trained and complete a medication competency assessment should assistance be required. All staff that administer medication are competent and have received medication management training. The facility uses a robotic sachet medication management system for the packaging of most tablets. The RN on duty reconciles the delivery. Medication charts are written correctly by medical practitioners and there was evidence of three monthly reviews by the GP. Medicine administration charts sampled were correctly completed by staff. Standing orders are not used and no resident was self-administering medicines on audit day. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a fully functional kitchen and the majority of food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the cooks work closely with the RNs on duty. The two cooks have food safety qualifications. The cooks follow a rotating seasonal menu which has been developed according to the nutritional guidelines for the elderly. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family/whanau members interviewed were very happy with the quality and variety of food served. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to residents should this occur and communicates this decision to residents/family/whanau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI and additional assessment tools were completed and assessments were reviewed at least six monthly or when there was a change to a resident’s health condition 9n files sampled. Care plans are developed on the basis of these assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long term care plans reviewed described the support required to meet the resident’s goals and needs and identified allied health involvement. Residents and their family/whanau are involved in the care planning and review process. Short term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses (RN) and caregivers follow the plan and report progress against the plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the wound specialist nurse). If external medical advice is required this will be actioned by the GP. RNs have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.  Wound assessment, monitoring and wound management plans are in place for seven residents which are being appropriately managed. The RNs have access to specialist nursing wound care management advice. |
| Standard 1.3.7: Planned Activities  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. | FA | Two activities coordinators are employed on various days during Monday to Saturday to operate the activities programme for all residents. Each resident has an individual activities assessment on admission and from this information an individual activities plan is developed by the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored by activities staff. Group activities reflect ordinary patterns of life and include planned visits to the community. The individual activity plan is reviewed when the resident’s long term plan of care is reviewed. Residents and families interviewed commented positively on the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans are evaluated by the registered nurse (RN) within three weeks of admission. The long term care plan is evaluated at least six monthly or earlier if there is a change in health status. The RN maintains a list of all residents due for review to ensure reviews occur in a timely manner. There is a three monthly review by the GP and the GP participates in the six monthly multidisciplinary reviews. All changes in health status are documented and followed up. Care plan reviews are signed by an RN. Short term care plans are evaluated and resolved or added to the long term care plan if the problem is on-going as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals were made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident’s condition had changed and the resident was reassessed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness. There is a water powered lift that is used by residents and staff. The building has a number of alcoves and lounge areas. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. The facility has been recognised by ACC Workplace Safety Management for its health and safety practices. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Most bedrooms have their own ensuites. A small number of bedrooms share ensuites. One room uses a communal toilet and shower. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The communal areas include the main lounge and dining area. In addition there were a number of smaller lounges spaced throughout the facility. The communal areas were easily and safely accessible for residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The facility is cleaned by dedicated cleaning staff who work on a roster which operates seven days a week. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored by the manager through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.  All laundry is done on site by dedicated laundry staff. There is a sluice area and room for soaking soiled clothing. Residents and relatives interviewed were satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved emergency evacuation plan in place and fire dills occur six monthly. There are emergency and disaster manuals in place to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There was a first aid trained staff member on every shift. The service has alternative energy sources in case of power failures including a gas BBQ. There are civil defence kits in the facility and stored drinkable and non-drinkable water on site. Electronic call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is secured at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Malyon House has an established infection control (IC) programme. The infection control programme has been appropriate for the size, complexity and degree of risk associated with the service. The clinical manager has been the designated infection control nurse with support from the registered nurses and other Cavill Group infection control coordinators. The IC team meets to review infection control matters. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually at an organisational level. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme at Malyon House. The infection control (IC) coordinator has maintained her practice by attending Tauranga Infection Control group meetings. The infection control team is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least two yearly. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control coordinator with support from the registered nurses. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved (there has been no recent outbreaks). Information was provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2014. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The clinical manager is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly resident infection data sheet and then graphed with graphs placed on noticeboards for staff. The data has been monitored and evaluated monthly and annually at facility and organisational level. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Restraint minimisation is overseen by a restraint coordinator who is the clinical manager. There were four residents requiring bedrails or a lap belt as restraint. Three hospital residents were using bedrails as enablers. The use of enablers is voluntary, requested by the resident. A full restraint assessment is completed prior to implementing the enablers. There is evidence of the residents consenting to the enabler. In addition, there is evidence of monitoring of residents who were using enablers. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint coordinator is the clinical manager. The restraint approval process and the conditions of restraint use are recorded on the “restraint assessment, alternatives and informed consent form”. Consent for restraint use is logged in the restraint register. Assessments are undertaken by suitably qualified and skilled staff such as the RN and GP in partnership with the resident and their family/ whanau. The multi-disciplinary team is involved in the assessment process. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint assessment, alternatives and informed consent form is completed and signed by the resident representative (family / EPOA), RN, and GP and this was documented in the two residents files for residents who use restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The restraint policy requires that restraint is only put in place where it is clinically indicated and justified. The policy requires that restraint, if used, be monitored closely and this is done daily using a monitoring form. The assessment for restraint includes exploring alternatives, risks, other needs and behaviours. Two files were reviewed for residents with restraint. The review identified clear instructions for use of ‘bedrails or the lap belt, approval process, risks and monitoring requirements.  Restraint intervention is fully described in the care plan with daily monitoring records completed by staff.  The restraint register is in place which also shows discontinued restraints. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Two files were reviewed of residents requiring bed rails or a lap belt as a form of a restraint. The use of restraint episodes are evaluated in the care plan six monthly and documented, if a change occurs it is documented at the time. All episodes are also reviewed by the restraint coordinator six monthly. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint coordinator is the clinical manager. The restraint approval group at Malyon House includes all staff through the staff meeting format and clinical meeting format where restraint is a standing agenda item. An annual audit is completed on restraint use. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.4  The service is able to demonstrate that written consent is obtained where required. | PA Low | One of the six residents who were reviewed in depth did not have a signed admission agreement. This resident has lived at the facility for many years and is not considered competent to sign formal documents such an agreement. This resident has no formal representative to administer their affairs. Following discussion during the audit staff have sought external advice about this person’s personal and property rights. | One of six residents did not have a signed admission agreement that includes consents. | Ensure all residents have a signed admission agreement that includes consents.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Internal audits are completed by other manager’s within the Cavill Group. Internal audits completed in 2014 include human resources (March), restraint (May), Food and laundry (June), infection control and waste (July), medication (August), consumer rights, exceptions and complaints (September) and pre entry and entry and recording (October). | In 2014 the service delivery and building and maintenance audits were not completed according to the audit schedule. | Ensure that all areas of the service are monitored with the internal audit programme.  180 days |
| Criterion 1.3.1.4  Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies. | PA Low | The agreements for six residents were reviewed. Three of the six residents had a signed admission agreement that was not signed on or before admission when they were admitted from the community in a planned manner; and one of the six residents had no service agreement in place (link 1.10.4). The other three of the six residents had signed service agreements after admission, as they had been admitted directly from a hospital. | One resident does not have a signed service agreement (link 1.10.4) and two residents had not signed their service agreements on or before the day of admission when they had been admitted in a planned manner from the community. | Ensure all residents have a signed service agreement on or before the day of admission unless they are admitted directly from a hospital and there has been insufficient time for them to consider the content of the service agreement.  90 days |

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

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End of the report.