# Avatar Management Limited

## 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](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:** Avatar Management Limited

**Premises audited:** Maida Vale Retirement Village

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

**Dates of audit:** Start date: 27 October 2015 End date: 29 October 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:** 69

# 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

The Maida Vale facility is part of the Maida Vale Maygrove Retirement Village complex in Bell Block, New Plymouth. The service provides rest home, hospital and residential disability services for up to 91 residents.

An unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service’s funding contract with the Taranaki District Health Board. The onsite audit included the review of documentation and residents’ files, observations and interviews. Interviews were conducted with management, staff, residents, family/whanau and a general practitioner to verify the documented evidence. This audit report is an evaluation of the combined evidence on how the service meets each of the relevant standards.

There were three shortfalls identified in the previous certification audit related to incident reporting, updating assessments and meeting timeframes for updating of care plans. These areas are now addressed. At this audit there are three new areas identified as requiring improvement in relation to evaluation of care plans, medication management and ensuring policies reflect current practice.

## 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. |

The service promotes an environment for open disclosure and clear communication with residents and family/whanau. There are processes in place to access interpreting services when this is required.

The service has a documented complaints management system implemented. There were no outstanding complaints at the time of audit

## 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 organisation's mission statement and vision have been identified in the business plan. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents’ needs. The management team regularly review the business, risk and quality plans.

The quality and risk system and processes support safe service delivery. Corrective action planning is implemented to manage any areas of concern or deficits identified, with documentation showing the evaluation and follow up of the corrective actions. The quality management system includes an internal audit process, complaints management, resident and relative satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff. Reporting processes include external benchmarking so data can easily be compared to previously collected data and other aged care services.

The day to day operation of the facility is undertaken by staff that are appropriately experienced, educated and qualified. This allows residents' needs to be met in an effective, efficient and timely manner.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

Care and interventions are provided to meet the residents’ needs. Two areas identified for improvement in the previous audit related to the timeliness of care planning updates and assessments being used to inform care planning decisions are now fully attained. In the six files reviewed all timeframes identified contractual requirements are met by the service. The service has a detailed system in place to show when each resident’s six monthly review is due. This process is monitored by the unit charge nurses.

Residents are medically admitted by the general practitioner (GP) within two days of admission to the facility and a minimum of three monthly full medical reviews are documented.

The care plans identify each resident’s physical, psycho-social, cultural and spiritual needs following an interRAI assessment. Additional assessment tools are used for pain, mini mental and skin integrity. All issues identified during assessment are identified on the resident’s care plan. Six monthly evaluations are undertaken but they do not identify if the resident’s goals have been achieved.

Short term care plans were sighted in all the residents’ files reviewed. These are put in place for issues that can be resolved, such as infections or wound care.

Staff demonstrated knowledge in providing interventions and services for the residents. This is supported by residents and family/whānau interviewed who reported a high level of satisfaction with the care provided.

Planned activities are based on the interests and strengths of the residents. Activities offered cater for all age groups and acuity levels.

There are policies and procedures in place related to medication management. Not all policy requirements are followed for the management of respite care residents. Staffs receive regular education to ensure ongoing competence with medications. Safe storage and administration of medicines was understood by staff spoken to.

The menu has been approved by a registered dietitian as appropriate for the residents at Maida Vale. The kitchen is resourced appropriately and staff are aware of resident’s individual needs. Kitchen staff have attended appropriate education and can verbalise safe food practices.

## 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. |

Each of the buildings have a current building warrant of fitness.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Bed rails and lap belts are the approved restraints in use. When enablers are used they are voluntary and the least restrictive option to maintain the resident’s independence, safety and mobility. Restraint and enabler use is clearly documented in the resident’s care plan.

## Infection prevention and control

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

There is monthly surveillance of infections. The infection surveillance data is analysed and trended, with actions implemented to reduce the re-occurrence of infections

## 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 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 38 | 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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | Complaints management is explained as part of the admission process for residents and family/whānau and is part of the staff orientation programme and ongoing education. This was confirmed during interviews. Residents and family/whānau confirmed that the management’s open door policy makes it easy to discuss concerns at any time. Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur.The complaints and concerns register records all complaints and concerns, dates and actions taken. The complaints reviewed were addressed within time frames that comply with Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). There were no outstanding complaints at the time of audit. The service also conducts a yearly analysis across all aspects of the service (eg, kitchen, care, household, maintenance, villas and staff).  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The residents and family/whanau report they receive information in an open and honest manner that reflects the service’s policy of open disclosure. The incident and accident forms sighted record the informing of family/whanau of any adverse events and updating of any changes with their relatives. Staff demonstrated knowledge on their responsibilities related to open disclosure. At the time of audit, all residents are able to communicate effectively in English. When required the service can access interpreting services through the DHB. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Care and services at Maida Vale are planned to meet the needs of the residents at rest home, hospital and residential disability services (for younger disabled people (YPD) age under 65) levels of care. At the time of audit there were 69 residents (34 rest home, 31 hospital and four YPD) receiving rest home and hospital level of care. There are a further 13 people living in the apartments who are living independently. The service consists of Woodrow Grove, Mountain View, Mountain View Apartments and the Ocean View apartments and home based services. Woodrow Grove has 34 dual purposes beds (rest home and hospital level of care), Mountain View has 12 rest home only beds and 24 dual purpose beds, Mountain View Apartments has 9 rooms that are independent living units that can also provide rest home or hospital level of care, and the 12 Ocean View Apartments are independent units that can provide rest home level of care. Maida Vale is located within a wider retirement living village that also provides independent living villas and home based community services. The vision and mission statements of the organisation are documented and displayed throughout the service. The overarching purpose, values, scope, direction, and goals are identified in the annual quality and risk plan. The board of directors is responsible for the development of the strategic plan (April 2013 to March 2017) which sets long term and short term goals. Progress against the strategic plan, quality and risk plans is formally reviewed at the monthly management meetings. The organisation has set key performance indicators for all aspects of service delivery and has this externally benchmarked on a quarterly basis. The owners/board of directors have the overall role of governance and strategic direction. There is a clinical services manager who is responsible for the clinical aspects of service delivery. They have been the clinical service manager since December 2013. The clinical services manager has previous experience in aged care management and nursing. The clinical services manager is a registered nurse (RN) with a current practising certificate. Job descriptions identify the nurse manager’s experience, education, authority, accountability and responsibility for the provision of services. The clinical services manager participates in ongoing education to ensure they have at least 8 hours of education related to the management of aged care services. Resident and family satisfaction surveys and interviews with residents and family at the time of audit provided evidence that residents and family/whānau are satisfied with the care and services provided. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The service has a quality and risk management system which is understood and implemented by the staff. There is a quality plan and a risk management plan. These include the development and updates of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. All reporting is linked to benchmarking of key performance indicators with an external benchmarking service. This information is used to inform ongoing planning of services to ensure residents’ needs are met. In addition to the internal quality and risk systems and external benchmarking the organisation have also implemented a healthcare evaluation and quality improvement accreditation programme. The continuous quality improvement (CQI) and risk committee meets monthly. Minutes of the CQI meetings evidences discussion of legislative compliance, compliments/complaints, education/training, resident infection rates, antimicrobial usage, and reports from the household services, recreation officer, the training school and the two charge nurses. The CQI meetings also review the outcomes of audit results (internal and external), satisfaction survey results, restraint use, maintenance reports and incidents/accidents and falls for each unit. Policies and procedures have been developed and updated by the organisational management team with input from external specialists. Though the policies have been updated within the last two years the policies have not been updated to reflect the use of the interRAI assessment tool. Staff have access to current policies and procedures in each unit. The obsolete documents are securely archived onsite. The electronic records are backed up offsite. The quality improvement data is collected, analysed and benchmarked. The internal auditing plan covers all aspects of service delivery including resident care planning, the environment, infection control, resident and relative satisfaction. The internal audits sampled evidenced corrective planning to address any shortfalls. Feedback is provided to the appropriate levels of staff, for example food services to the cook, clinical audit outcomes to the caregiving staff. The service also has quality improvement forms based on suggestions from staff, residents and visitors for areas that can be improved on. The forms sampled record the improvement implemented and follow up of the evaluation of the effectiveness of the improvement. Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management and verbal examples of quality improvements were given.Actual and potential risks are identified and documented in the hazard register. There are interventions implemented to either eliminate, isolate or minimise the hazards. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes. |
| 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 | The previous audit identified a shortfall in ensuring that all issues that are identified in response to an incident are actioned and that the incident/accidents analysis includes all types of incidents reported. This is now addressed, with the incident and accident reporting processes well documented and any corrective actions to be taken shown on the forms. Staff reported they report and record all incidents and accidents.Management confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated. Falls management strategies are implemented for residents who have falls. There is a monthly falls prevention meeting where all residents who have had a fall in the month are discussed. The physiotherapist and clinical services manager also attend this meeting and reports active falls prevention strategies are discussed for each resident. The clinical staff report that if there were any pressure injuries, they would be reported through the adverse event and quality systems. At the time of audit there is one resident with a long term pressure injury. Management understand their obligations in relation to essential notification reporting and knew which regulatory bodies must be notified. There have been no accidents that have required essential notification, though a number of incidents have been reported to the DHB. The owner/operator reports there has been times when they have informed the DHB when a nurse cannot be replaced and when the service had a suspect outbreak and went into lockdown. The notification forms for the DHB were sighted for these incidents. |
| 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 | Staff that require professional qualifications and annual practising certificates (APCs) have these validated as part of the employment process. A register is maintained of the staff and contractors who require an APC, with current APCs sighted for all who require them. Policies and procedures are implemented for human resources management that reflects good employment practice and meet the requirements of legislation. Newly appointed staff are police vetted upon employment, references are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies for their roles. Staff undertake training and education related to their appointed roles. Records of attendance and competency training is maintained. Education provided is refined to current accepted good practice, with staff providing feedback and evaluation of the in-service education provided. The education programme covers the contractual requirements, staff competencies and specific issues related to the aging process. The service has completed the required RN training on the interRAI assessment tool. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy identifies staffing levels and skill mix are maintained to meet residents’ needs and to comply with the funder’s contractual requirements and safe staffing guidelines. Rosters identified that at all times there are adequate numbers of suitably qualified staff on duty to provide safe and quality care. A review of rosters showed that staff were replaced when on annual leave or sick leave. There are appropriate numbers of administration, activities, maintenance, cleaning and laundry staff to meet the needs of the service and residents. The clinical services manager reported that additional staff would be rostered to meet residents’ needs and this was confirmed by staff interviewed. This occurred during a recent infection outbreak. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents’ needs. The retirement village and home based services are staffed separately from the aged care facilities. Residents stated their needs are met in a timely manner. |
| 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. | PA Low | The service had detailed medication management policies and protocols that reflect good practice and legislative requirements to guide staff. However for respite care residents, policy is not followed. Medicines are stored appropriately in designated locked medication rooms and administered from purpose built medication trolleys. Most medication is dispensed into blister packs. Medication that cannot be blister packed has clear resident identification for each item. Evidence of medication reconciliation is documented and identifies pharmacy involvement. The service uses an electronic medication recording system for rest home and hospital level care residents. Respite care residents are managed using a paper based system. Management of respite care residents’ medications is not uniform throughout the organisation. Mountain View and Woodrow Grove units use different documentation which is not pharmacy generated. (Refer comments 1.2.3.3)Medications are administered by staff who have completed medication competencies. The medication rounds observed during the audit were performed in a manner that demonstrated competency and safe administration processes. Medicines that require refrigeration are stored in separate fridges in the medication rooms.The medication records are reviewed by the GP at least three monthly and this is recorded electronically on the medication record. There is a specimen signature maintained for all staff who administer medicines. There are no standing orders. There are no residents who self-medicate but safe practice is reflected in policy. Medication errors are reported via an incident/form system and recorded in the resident progress notes appropriately. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The kitchen is well equipped and staff hold current food safety certificates as identified in staff education files. The menu was reviewed and approved by a dietitian in May 2015 to ensure it is appropriate for the nutritional needs of the residents. There is a board noting residents’ dietary preferences, dietary modifications and special diets. All residents’ files have a dietary profile which are available to kitchen staff. All newly admitted residents have a full dietary review undertaken by the dietitian as part of the admission process. Any resident with weight management concerns or special dietary requirements are seen by the dietitian on an as needs basis. Dietitian input is sought for residents’ annual multidisciplinary reviews.All aspects of food procurement, production, preparation, storage, delivery and disposal are monitored by the chef and documentation identifies that current legislation and guidelines are met. Meals sighted were visually appealing and match menu requirements. Residents confirmed during interview that they are offered choices and that their likes and dislikes are catered for. Only one resident stated during interview that not all their dietary likes are met and this was addressed at the time of audit. All other residents’ were satisfied with the food service.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | In all files reviewed assessment tools were used appropriately to inform the care planning process. This was an area identified for improvement in the previous audit and is now fully attained. All residents have information gathered using the interRAI assessment system along with additional tools for skin integrity, continence and pain. The goals set from this information is resident centred.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The care plans described the interventions and services to meet the residents’ needs. All interventions shown matched and are supported by appropriate assessment tools. Care planning identifies interventions for the resident’s physical, psycho-social, cultural and spiritual needs. Staff demonstrated knowledge of the interventions required for each resident. Residents and family/whānau members reported a high level of satisfaction with the care and interventions provided. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Clinical management policies and procedures include the interRAI nursing assessment on admission (refer comments in criterion 1.2.3.3). Alerts raised on the interRAI tool are used to inform ongoing care planning along with any additional assessments undertaken. Interventions put in place are consistent with assessment findings and aim to assist residents in meeting identified goals. The services and interventions delivered to residents is guided by the care plan information. There is evidence of short term plans for any event that does not require long term interventions, such as infections. As observed on the day of the audit and from review of the care plans, support and care was individualised and resident focused. Staff demonstrated good skills and knowledge of the individual needs of residents. The residents` files showed evidence of consultation and involvement of the family/whānau. The residents and family/ whānau interviewed reported a high level of satisfaction with the care and service provided. |
| Standard 1.3.7: Planned ActivitiesWhere 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 | There are planned activities seven days a week. The two activities coordinators report that resident feedback is sought following all activities to ensure the current programme is meaningful to the residents. This is supported in residents’ meeting minutes sighted. Activities are amended to match residents’ requests and to gain additional community support, such as school group visits. Activities are modified to match residents’ capabilities and verbal requests. Regular changing monthly themes, such as the Melbourne Cup races, are used to ensure current events are highlighted during activities offered. The four residents under the age of 65 years plan their own activities which are supported by the activities coordinators. This is confirmed in formalised meeting minutes sighted relating to the younger persons group and by the two under 65 years old residents interviewed.The documented activities programme covers physical, social, recreational and emotional needs of the residents. The monthly activities plan is printed and distributed to residents and posted on prominent notice boards. Evaluation of activities includes the use of attendance sheets and verbal feedback. The activities coordinators regularly document resident attendance and feedback in the resident notes so that all staff are aware of resident interests. Residents are encouraged and supported to remain part of the greater community and many go off-sit to attend social activities and groups, such as craft groups, church functions and coffee outings. Residents confirmed that they enjoyed the activities offered and that their needs are met. Family/whānau members state they are always made to feel welcome to attend any activities they wish. The monthly activities plan is printed and distributed to residents and posted on prominent notice boards.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | Regular evaluations are recorded on the care plan but they do not all describe how the resident is progressing towards meeting their goals. In three of the six files reviewed the evaluation described updated interventions. Where a resident’s progress is different from expected the service uses a short term care plan to identify and record any temporary needs. All files reviewed had well documented short term care plans for wound care, antibiotic use, and any changes to mobility that is short term. Changes to residents’ care needs are also shown in progress notes and discussed at handover. This is confirmed during staff interviews.The three residents reviewed using tracer methodology confirmed changes have been made to their care interventions to meet their current needs. All residents and family/whānau members interviewed confirmed changes are made to interventions as their needs change.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Each of the buildings that make up the Maida Vale care services and apartments have a current building warrant of fitness. There have been no changes to the structure of the buildings that have required the approved evacuation scheme to be updated. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. Staff are responsible for completing an infection reporting form for all residents who are suspected or diagnosed as having an infection. The infection control officers review all residents' forms to ensure residents meet the criteria. Infections are summarised on a monthly basis and reported per category of infection and per wing. The type of infections are categorised as new or existing or present on admission. Infection rates are reported at the continuous quality improvement and risk management meetings. A representative from the DHB is involved with evaluating infection surveillance data submitted. The infection surveillance data is also externally benchmarked on a quarterly basis. The infection surveillance data analysis records any trends and the actions implemented to reduce infections. The surveillance data for July 2015 records the service implemented actions when there was an outbreak. The clinical services manager completed an evaluation of the management of the outbreak. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Bed rails and lap belts are the approved restraints in use at the time of audit. These have been consented to by the resident and/or enduring power of attorney. When enablers are used these are voluntary and the least restrictive option for the resident. All restraints and enablers are used for the safety and comfort of the resident. Restraint and enabler use is clearly identified in the resident’s file. Staff are aware of the restraint minimising strategies and ensuring enabler use is voluntary and encourages resident independence and safety.Restraint is actively minimised. At the time of audit there is one lap belt restraint and six enablers (three beside rails and three lap belts) as identified in the restraint register sighted and confirmed during staff interviews.  |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.3The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | The policies have been updated in the last two years. However the care planning policies have not been updated to include the use of the interRAI assessment tool. The organisation has started to update these policies on the day of audit. | The policies have not been updated to include the use of interRAI. The policy for medicine management of respite residents does not provide clear guidance on the forms to be used.  | Provide evidence that policies are updated to reflect current practice.180 days |
| Criterion 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | Safe and appropriate prescribing, dispensing, administration, storage, disposal and reconciliation occurs. Safe administration processes were witnessed Medicines management is implemented according to policy for rest home and hospital level care residents. Medicine management policy is not followed for respite care residents.  | Medicine management policy requires a pharmacy generated signing sheet and currently these are not obtained by staff. Staff use different forms in each unit (Woodrow Grove and Mountain View) to sign when medications are given. | Ensure all medication management policies are followed.180 days |
| Criterion 1.3.8.2Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Goals are resident focused. Evaluations are undertaken six monthly but in Mountain View they do not identify if the residents’ goals are being met. The evaluation column is being used incorrectly and shows the changes made to resident care rather than evaluation of progress made towards the goal shown. Evaluations are clearly documented in the files reviewed in the Woodrow Grove unit. | Three files reviewed in the Mountain View unit show that the evaluation column of the care plan does not identify if the resident’s goals are being achieved.  | Ensure evaluations indicate the degree of achievement or response to the support and interventions put in place to meet residents’ goals180 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.

|  |
| --- |
| No data to display |

End of the report.