# Metlifecare Limited - The Orchards

## Introduction

This report records the results of a Certification 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:** Metlifecare Limited

**Premises audited:** The Orchards

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

**Dates of audit:** Start date: 28 June 2016 End date: 29 June 2016

**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:** 35

# 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

Metlifecare Limited – The Orchards (The Orchards) is one of 24 facilities owned and operated by the Metlifecare group, eight of which have care facilities. The Orchards provides rest home and hospital level care for up to 36 residents. There is a village on the same site; this was not subject to this audit.

This certification audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, families/whānau, management, staff and a general practitioner. Feedback from residents and families/whānau members was positive about the care and services provided.

There are 19 areas identified for improvement from this audit - four of which are considered high risk. The high risk findings relate to inaccuracy of quality and risk data recording and reporting, non-reporting of all incidents and accidents, non-compliance with timeframes for stages of service provision, and not all interventions are shown to meet residents’ needs.

Other areas for improvement relate to clinical practice which does not always reflect good practice standards, open disclosure, completion of clinical documentation, assessments, activities planning and short term care plans. Improvements are required in relation to accuracy and inconsistency of data, evaluation of residents’ progress, training of staff in food safety, management of restraint and reporting and recording of infection control data.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The residents and family/whanau reported they are treated with respect, dignity and are not subject to abuse, neglect or discrimination. All rooms are single occupancy to maintain residents’ privacy.

There are appropriate processes and procedures implemented to ensure residents who identify as Maori, or any other culture, have their individual beliefs respected and acknowledged. If required, the service can access an interpreter.

There are organisational policies, procedures and systems in place that reflect evidence-based practice.

The residents, their families, or enduring power of attorneys (EPOAs), are involved in the care planning, decision making and consent processes. Where there is an advance directive, the staff act on its instructions.

The organisation respects and supports the right of the resident to make a complaint. The service has a complaints register and the information is recorded to meet all the requirements of the standard. There is one open complaint which was sent to the Waitemata District Health Board (WDHB) 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 medium or high risk and/or unattained and of low risk. |

Metlifecare Limited’s governing body ensures that business and strategic planning is in place to cover all aspects of service delivery. The Orchards has a personalised business plan to reflect the services offered. The goals set are reported against quarterly to head office. The village manager, who has been in the role two weeks, is responsible for the overall management of the facility and the nurse manager, who has been in the position for three months, oversees all clinical matters. The nurse manager is a registered nurse.

At facility level the quality and risk system and processes are documented.

Corrective action planning is implemented to manage known areas of concern or deficits. The quality management systems include an internal audit process, complaints management, incident/accident reporting, annual resident surveys, restraint and infection control data collection.

Quality and risk management activities and results are shared among management, staff, residents and family/whānau, as appropriate.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented meet safe staffing levels. There is an education calendar in place which identifies regular educational sessions are conducted and attended by staff.

## Continuum of service delivery

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

The entry requirements for rest home and hospital level of care are clearly documented. Residents and family/whanau receive accurate information on admission to the service. There are processes in place to record and notify the referrer if a potential resident is declined entry to the service.

The service has implemented the required electronic assessment tool (interRAI). The care plan format describes the required support and/or intervention to achieve the desired outcomes. The evaluation record showed the progress the resident is making towards meeting their goals.

Referral to other health or disability service providers is appropriately facilitated by the general practitioner or registered nurse. There is an appropriate process and risk assessment to facilitate any discharge or transfers to other providers.

The service provides an activities programme.

There are processes in place for safe medicine administration. The service has implemented a cloud based medicine management system. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage.

The residents and family/whanau report satisfaction with the meal services.

## Safe and appropriate environment

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

There are documented emergency management response processes which are understood and implemented by the service providers. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness and the service has an approved interim fire evacuation plan. Medical equipment is checked to meet legislative requirements. Electrical safety checks are not required as every room is on a separate circuit breaker should any faulty equipment be plugged in.

Documentation sighted and interviews with residents and families/whānau identify that the facilities meet residents’ needs with the provision of appropriate furnishings, single bedrooms, adequate toilet, bathing, hand-washing, and dining and relaxation areas.

Reactive maintenance occurs in a timely manner. As this is a newly built facility the contractors have been responsible for most maintenance issues until June 2016.

The facility is appropriately heated and ventilated. The residents have a balcony area off the main lounge and can access other outdoor areas from the lower level.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. Policy states that an assessment is required for enabler use.

There is a nominated restraint coordinator who is a registered nurse.

At the time of audit there is no restraint and one enabler in use. Restraint approval and assessment processes were identified for one approved restraint which has since ceased.

Alternative techniques are identified in policy and procedures as a means of gaining a restraint free environment. The only recorded restraint was in use for 10 weeks.

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

There are appropriate systems in place for infection prevention and control. The documented policies and procedures for the prevention and control of infections are regularly reviewed. The infection control programme is reviewed annually. The service and the infection control coordinator have access to advice from the organisational clinical management team, as well as external advice as required.

Surveillance for infections is conducted monthly. The infection control data is benchmarked with other Metlifecare services monthly and external benchmarking occurs three monthly. The infections that have been captured in the surveillance data have been analysed.

## 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 | 37 | 0 | 4 | 5 | 4 | 0 |
| **Criteria** | 0 | 82 | 0 | 7 | 8 | 4 | 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 | The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility. Staff demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights, such as knocking on doors before entering, closing doors during cares and resident choices were respected. The residents and family/whanau do not report any concerns about their rights not being respected and the standard of care provided. There are a number of corrective actions in the service delivery standards (1.3.3, 1.3.4, 1.3.6, 1.3.8) that could impact on the services ability to meet Right 4 of the Code – The Right to Services of an Appropriate Standard, if corrective actions are not implemented in a timely manner. |
| 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. | FA | The residents' files reviewed had consent forms signed as part of the admission agreement; they were signed by the resident or their next of kin/enduring power of attorney (EPOA). There were consent forms sighted for other procedures, such as vaccinations.  The files contained copies of any advance care planning, advance directives and living wills that record the resident’s wishes for end of life care. Staff acknowledged the resident's right to make informed choices. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The residents and family/whanau reported that they were provided with information regarding access to advocacy services. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the resident information booklet. Education on advocacy and support is conducted as part of the organisational orientation and in-service education programme. |
| 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 | There are no set visiting hours and visitors are encouraged to visit. The residents and family/whānau reported van outings to the outside community. Residents are supported and encouraged to access community services with visitors/family and have some access to the facilities within the wider retirement village complex. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The Orchards implements organisational policies and procedures to ensure complaints processes which reflect a fair complaints system. Complaints are registered at Metlifecare head office electronically and a complaints register is kept on site. Residents, family/whānau and staff reported during interview that they understand the complaints processes in place and are aware of where to find written complaints forms.  Management confirm complaints information is used to improve services as appropriate. Complaints are a standing agenda item for both management and staff meetings as confirmed in meeting minutes sighted.  One complaint which was sent to the Waitemata District Health Board (WDHB) has resulted in the need for three improvements. The letter containing this information was only received by the service on the last day of audit. As confirmed by the portfolio manager from the WDHB at the closing meeting, the complaint remains open pending the improvements being actioned.  All on site complaints have been actioned and closed off at the time of audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The Code is discussed with residents and family/whanau at the time of admission and information is also available in the information booklet. Information is displayed about the Nationwide Health and Disability Advocacy Service and the Code. These are in different languages and easy to ready formats for people living with a disability. The families/whanau had high praise for the way that the staff treat and interact with their family member. The overall satisfaction in the March 2016 survey records a 100% overall satisfaction with 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 | All rooms are single occupancy, with one couple sharing a room and having the second room as their living space. These two residents did not wish to have dividing curtains separating their beds and their care plans have needs identified to ensure the couple’s privacy is maintained.  The doors on all the residents’ rooms are double width to provide easy access and mobility for residents, though when fully opened provide a direct view into the resident’s rooms and bed space. The residents and family/whanau did not express any concerns about their privacy not being maintained, the service may wish to consider some additional interventions, such as privacy signage on the doors that indicates that staff cannot come into their bedroom unless they are invited to enter by the resident.  The services are planned so the residents can maintain as much independence as possible. Family/whanau reported satisfaction with the care provided and have no concerns about abuse or neglect.  Staff demonstrated knowledge on identifying any suspected abuse and know who to report to if they suspect abuse or neglect. |
| 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 managers reported that there were no known barriers to Māori residents accessing the service. There are no residents who identify as Māori at the time of audit. Staff demonstrated knowledge of the importance of whanau in the care and support of residents who identify as Māori. There are resources and information available to staff if additional information and advice is required to support residents who identify as Maori. |
| 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 | The care plan format has sections for recording the resident’s individual culture, values and beliefs. The residents’ files reflect that services are provided that are responsive to the individual cultural and spiritual needs of each resident. Residents of different cultures had interventions and reported that their individual beliefs, including meal requirements, are provided for. There is cultural diversity in the staff, with residents and family/whanau stating they ‘appreciate and enjoy’ this cultural and gender diversity. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Individual employment contracts have information on professional boundaries. The orientation and induction programme includes staff education on maintaining professional boundaries. The residents and family/whanau report they have no concerns about discrimination. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | PA Moderate | The organisation has policies, procedures and systems in place that reflect evidence-based practice. It was not always evidenced that these systems were implemented in practice. The residents, family/whanau and GP did not express any concerns regarding the quality of care implemented. Also refer to Standards 1.2.3, 1.2.4, 1.3.3, 1.3.4, 1.3.6, 2.2.3 and 3.5.7. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Moderate | The service has not required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed.  The residents’ files have a communication sheet that records contact and communication with family/whanau. The incident forms sighted do record if the nominated family member is informed of the incident. There is an area for improvement to ensure that all incidents evidence open disclosure. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation’s philosophy, mission statement and values are clearly documented. To meet policy requirements, The Orchards has a personalised business plan which is in line with the direction and objectives of the organising body. The business plan identifies how services are planned to address residents’ needs. Documented annual goals are reported against regularly to the organisation’s board of trustees. Quarterly reporting against the set goals in the business plan were sighted.  On the days of audit there were 35 rest home beds occupied. This consisted of seven rest home and 28 hospital level care residents. All 36 beds at the facility can be used for either rest home or hospital level care.  The management team consists of the village manager who has been in the role for two weeks and the nurse manager who has been in the role for three months. The nurse manager is a registered nurse with a current practising certificate and is responsible for services and care delivery within the care unit. The nurse manager has 26 years’ management experience in aged care both in New Zealand and overseas. They are actively involved in DHB cluster group meetings for aged care and have sat on a steering group committee related to the aged care/DHB partnership discussions.  This is the village manager’s first role in the health industry but they have a background in hospitality where they worked in senior management roles for eight years. The village manager holds a diploma in Hotel Management and a diploma in Food and Beverage. The village manager stated they are supported and guided by head office and that all aspects of the role were covered during orientation.  The organisation’s clinical quality and risk manager represented the organisation on the days of audit.  Interviews with residents and family/whānau confirmed that their needs were met by the service. The resident satisfaction survey results from March 2016 indicate a 100% overall satisfaction rating for care provided. This was supported during resident and family/whanau interviews conducted during audit. No negative comments were received on the days of audit. |
| 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 | During a temporary absence of the nurse manager the senior registered nurse would undertake the role with the support of the clinical quality and risk manager from head office. The village manager’s role will be covered by support staff and with assistance from the nurse manager and staff from Metlifecare head office as required.  This process would be overseen by Metlifecare head office and support would be given as required to ensure all roles are fully covered. |
| 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 High | The service has a quality and risk management system in place which includes the development and update of policies and procedures at organisational level, internal audits, incident and accident reporting, health and safety reporting, restraint, infection control data collection and complaints management. However, not all data is accurately reported or recorded. 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 policies and procedures sighted were up to date.  Quality data collected is analysed at facility and at governance level. Results are trended and benchmarked against previously collected data and the seven other care units. At facility level this information is used to inform ongoing planning of services. Not all quality data is made available to inform the results shown in trending and benchmarking.  Actual and potential risks are identified and documented in the hazard register and in the quality and risk plan. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes which are taken to the health and safety meeting which is part of the quality meetings. Health and safety management is overseen by the village manager.  Resident and family/whānau interviews confirmed any concerns they have were addressed by management. |
| 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. | PA High | The current nurse manager confirmed they are aware of the requirement related to statutory and or/regulatory reporting obligations including pressure injury reporting.  Adverse event reporting requirements are clearly identified in policy; however, not all requirements are being implemented. For example during interview, staff reported two infection control outbreaks since the facility has been open, this could not be verified at the time of audit due to incomplete documentation, refer to comments in criteria 1.2.3.1 and 3.5.7.  Staff also reported two instances of resident bruising for which no incident forms could be found.  Incidents and accidents which are reported and recorded are shared at all levels of the organisation, including any follow up actions required. Follow up actions are reported on the incident and accident forms. This is confirmed in the incident and accident forms sighted in residents’ files.  Family/whānau members interviewed stated they are notified of any adverse events or concerns staff have about their relatives.  Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. |
| 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. | PA Low | Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. This was reflected in the seven staff files reviewed. All roles have job descriptions that describe staff responsibilities. Staff complete an orientation programme with specific competencies for their roles. The nurse manager confirmed that some competencies, such as medication management will be repeated annually. Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis.  The organisational education calendar sighted identifies that staff undertake training and education related to their roles. Topics covered in annual training and education related to age care and health care services. Staff interviews confirmed the staff can access education related to their roles. Only one member of the kitchen staff has undertaken food safety education. |
| 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 via the use of a ‘staffing level planning tool’ to meet residents’ needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified and experienced staff are on duty. All shifts are covered by a RN and clinical staff hold current first aid certificates.  Rosters are analysed at head office to ensure staffing numbers match residents’ level of care needs. Staffing levels include a night porter who responds to any village resident call outs. For example, there are three staff and a night porter rostered, seven nights a week.  A review of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks. Residents interviewed stated all their needs have been met in a timely manner.  The activities coordinator works Monday to Friday. The kitchen staff are employed by the village and cover seven days a week. There are dedicated laundry and cleaning staff seven days a week. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Health information is kept in secure areas in the staff area and these are not accessible or observable to the public. Archived records were able to be accessed. There was no private information on display in the facility. All records pertaining to individual residents demonstrated they are integrated. The archived records are securely stored onsite. The progress notes record the staff members name and designation. A signature verification log is also kept. |
| 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. | FA | The nurse manager oversees entry to the service. The enquiry form records all enquiries and if the potential resident has an appropriate assessment for rest home or hospital level of care. The resident information handbook contains accurate information about the service. All residents’ files contain an appropriate needs assessment for rest home or hospital level of care. The service updates any vacancy on the Eldernet website each weekday. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | When admission has been required to the acute care hospital, the service utilised the DHB’s transfer forms. The referral process documented any risks associated with each resident’s transition, exit, discharge, or transfer. This included expressed concerns of the resident and family/whānau and a copy of any advance directives. Along with the transfer form, the RN reported that the service also provides a copy of any other relevant information. |
| 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 observed medication procedures are implemented to meet legislative and best practice requirements. The service has a cloud based medication management system. The medications are stored in the locked medication trolley. Medications that require refrigeration are stored in a medication fridge, with recordings within the required range. The processes for controlled drug management meet requirements.  There are no standing orders or residents who self-administer their medications. There are policies and processes in place if a resident is assessed as competent to self-administer their own medications.  The medications are individually prescribed for each resident on the cloud based electronic records. Any changes in medicines are updated instantly once prescribed by the GP. The medications are delivered by the pharmacy in a pre-packed administration system. These medication packs and the signing sheets are checked for accuracy by the RN. The medication charts and prescriptions have the required information and are electronically signed/prescribed by the GP. The three monthly medication reviews are recorded on the medication chart/record.  All staff who administer medications are assessed as competent to do so. |
| 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 four-week rotational menu that has summer and winter variations. The menu is used across all the Metlifecare facilities. This menu has been reviewed by a dietitian within the last six months. Residents with specific nutritional needs have these met. The kitchen staff get a copy of the nutritional requirements for each resident. Nutritional supplements are available to residents assessed as requiring these (refer to 1.3.3.3). The residents reported satisfaction with the meals and refreshments provided, they report that they liked having the main meal as the evening meal.  The kitchen services are based on the food safety principles. There are appropriate processes in place for the purchasing, preparation and disposal of food that complies with current legislation and guidelines. There is one kitchen staff member who has food safety training (refer to 1.2.7.5). |
| 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 has to date not declined entry to a potential resident with an appropriate rest home or hospital level of care needs assessment. The nurse manager reported if the service is to decline entry to a potential resident, this would be recorded on the referral form. If the service is not able to admit the resident, the referrer, prospective resident and family/whanau would be informed of the reason why.  The agreement has clauses on the change in level of care process when the service can no longer meet the needs of the resident. As the service only provides rest home and hospital care, if residents are assessed as requiring secure dementia care with current interventions not meeting their needs, the resident is reassessed and referred to a service that is better able to meet their needs. The service has one current rest home level of care resident being reassessed for dementia level of care. The service reports they are able to safely maintain this resident at The Orchards until the assessment has occurred. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | The assessments and reassessments are conducted using the electronic interRAI assessment process. All but one file had an initial interRAI assessment (refer to 1.3.3.3). The service also uses their own paper based assessments for additional needs that are identified through the assessment process, this includes behaviour assessments, nutrition, falls, wound assessment, pressure injury risk. The assessment triggers from the interRAI assessment process and additional assessments required by the organisation identifying if a more in-depth assessment is required are not always conducted or used to inform the care plan. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The service has an electronic format for the care plans. A copy of the care plan is printed and maintained in the resident’s file (evidenced in all but one file - refer to 1.3.3.4). The care plan format includes the resident’s specific needs, goals/aims and staff interventions required to address those needs (refer to 1.3.4.2 to ensure all needs are captured). The care plans evidenced the resident’s or family consultation and input into their planning. The residents and family/whanau reported satisfaction with the care provided. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA High | All the residents and family/whanau reported satisfaction with the care and service delivery. The service’s care plans and clinical interventions were not always clearly documented or evidenced as being implemented. |
| 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. | PA Low | The current activities coordinator was appointed the week prior to the onsite audit. They have prior experience as an activities coordinator in the aged care setting. Though management, staff and residents report activities have been provided since the opening of the facility, there was limited documented evidence of this. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Evaluations are conducted at least six monthly, this was confirmed in the files reviewed of residents with admission over six months. The evaluation process includes conducting an assessment or reassessment using the interRAI process, recording the evaluation on the care plan evaluation form, then updating the care plan if this is required. The six monthly evaluations sighted records how the resident feels their goals have been met over the past six months. When there has been changes in the resident’s needs the service uses a short term care plan or makes changes to the long term care plan, however this process was not consistently implemented. |
| 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 | Their service has two GPs that provide coverage to the residents and are onsite at least two days a week. The residents can maintain their own GP if available. The GP or RN arranges for any referral to specialist medical services when it is necessary. The resident’s files have referrals to other health and diagnostic services, though it is noted that these were not always conducted in a timely manner or that advice and clinical instructions from other health providers is actioned (refer to 1.3.3.3). |
| 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 | Policy which describes safe and appropriate storage and disposal of waste substances is implemented at The Orchards to protect staff, residents and visitors from harm as a result of exposure to waste products. Yellow sharps bins are used for the safe disposal of medical waste, such as needles. Staff report their understanding of safe disposal processes.  Chemicals are stored securely and clearly labelled. Safety data sheets were sighted for the chemicals in use. Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons as required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which expires 9 March 2017.  There is a process in place to identify and manage maintenance both long term and reactive. Electrical safety testing is not required as every room is on its own circuit breaker. Clinical equipment is tested and calibrated by an approved provider. As most equipment was purchased less than one year ago (August 2015) it is still under warrantee.  The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. Day to day maintenance is undertaken as required as observed during the days of audit.  Outdoor areas have seating and shaded areas. Residents have a balcony off the main lounge and can use the village grounds to walk around if the wish.  Interviews with residents and family/whānau members confirmed the environment is suitable to meet their needs. |
| 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 adequate centrally located shower facilities for residents with separate staff and visitor facilities. All resident bedrooms have a toilet and hand-basin. There are 28 bedrooms with full ensuites. Additional toilets located in public areas of the facility which all have privacy locks. Hot water temperatures are monitored and remain within safe limits. |
| 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 bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Bedrooms are personalised to meet resident’s wants and needs and have appropriate areas for residents to place personal belongings. With the exception of one bedroom which a husband and wife have chosen to place both their beds in all bedrooms are single occupancy. The second allocated bedroom for the couple is being used for their lounge area with easy chairs and a television.  Resident and family/whānau members interviewed confirmed they were happy with their bedrooms and stated that privacy is never an issue. |
| 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 | Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. Lounge and dining areas are separate. One large internal lounge which has no exterior windows is managed so that only specific activities occur in the area. For example, watching a DVD. Activities can be undertaken in any of the lounge areas.  Residents and family/whānau voiced their satisfaction with the environment. |
| 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 service has documented procedures in place for cleaning and laundry tasks. Chemicals are securely stored and correctly labelled. The laundry is appropriately equipped with clearly defined clean and dirty areas. The equipment in the laundry is checked regularly by an approved contractor along with the specific chemical mixes being used to ensure laundry is cleaned to required standards. The facility is maintained to a high standard of cleanliness and to ensure this remains staff cleaning hours have been increased.  During interview, residents and family/whānau confirmed they are very happy with the cleaning laundry services provided.  Interviews with cleaning and laundry staff confirmed they comply with policies and procedures and they are happy with the products used. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked annually by an approved provider. (Last undertaken on 30 June 2015.  Emergency supplies and equipment include food and water. The civil defence supplies are checked monthly. The service has an approved interim fire evacuation plan dated 4 September 2015. This only covers stage two of the new build and stage three is due to open within the next few months. This will then complete the build and the fire evacuation plan will be updated. Six monthly trial evacuation drills occur and are well documented. (Last undertaken in March 2016).  Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting.  The security arrangements include staff checking that doors and windows are locked upon dusk. There is a night porter who works seven nights a week to cover night duty and as well as responding to any call bells activated at the village they undertake regular security checks throughout the night. There are external cameras which can be monitored by senior staff on a pocket held screen should visitors wish to enter the premises after hours. The front doors automatically lock at dusk. Staff and residents stated they feel safe at all times.  Call bells are located in all resident areas. Resident and family/whānau interviews confirmed call bells were answered in an acceptable timeframe. Timeframes are monitored three monthly by the nurse manager. |
| 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 | With the exception of one central lounge area, all other areas used by residents have at least one opening window which allows ventilation and natural light. The facility is ventilated by opening doors and windows. There is a documented process in place to ensure the lounge with no external windows is only used for specific activities that are of a short duration. Electric heating is used throughout the facility. Residents confirmed during interview that the facility remains at a suitable temperature throughout the year. |
| 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 | A RN is the designated infection control coordinator/nurse, they have been at the service for four weeks and are newly appointed to the infection control coordinator role. The infection control nurse has a job description that outlines their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meetings, which the senior management presents to the Metlifecare organisational management team on a monthly basis for review and benchmarking (refer to 1.2.3.6 for the accuracy of this data and 3.5.7 for reporting infection control matters to organisational management).  The review of the infection control programme has been reviewed within the last 12 months (January 2016), with this review documenting how the service is meeting their infection prevention and control outcomes since commencement of service delivery.  There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise relatives not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. Staff demonstrated good knowledge and application of infection prevention and control principles. |
| 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 | Infection control matters are discussed at the staff meetings conducted monthly. There are three monthly meetings with Metlifecare quality and management teams and the other infections control coordinators across the Metlifecare facilities, with this expert committee available for advice when required at any other times. If the infection control coordinator requires additional advice or support regarding infection prevention and control they can also access this through the DHB, GP or diagnostic services. |
| 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 policies and procedures have been developed by Metlifecare and the use of best practice policies, procedures and resources from a specialist infection prevention and control consultancy service. The policies and procedures cover all aspects of infection control management, including the correct use of personal protective clothing/equipment. These policies are appropriate to the services offered by the facility.  All staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions according the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The newly appointed infection control coordinator will be conducting most of the infection control education. There are some visiting specialists who provide infection control education. The infection control coordinator demonstrated current knowledge on infection prevention and control. The infection control coordinator has attended ongoing education on current good practice in infection prevention and control. The infection control coordinator has had a similar role in another aged care service. As required, infection control education can be conducted informally with residents, such as encouraging fluids with residents with recurrent urinary infections. |
| 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. | PA Low | There is monthly collection, collation and analysis of infections. The service uses standardised definitions, applicable to aged care, to identify infections. The type of surveillance undertaken is appropriate to the service. Data is collected on urinary tract infections, influenza, skin infections and respiratory tract infections. The infection surveillance data did not capture all the required reportable infections. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. It states that the service aims to minimise the use of restraint and to ensure that if restraint is necessary, to keep the resident safe from harm. The use of enablers is voluntary and the least restrictive option to meet the needs of the resident. Policy contains all necessary documentation related to the use of restraint.  The service had one enabler in use at the time of audit. One file contained signed approval for a restraint which is not being used as stated. Refer comments in 2.2.3.2 |
| 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 service has documented processes for determining approval of restraint. Approved restraints are clearly identified. The responsibility for restraint is shown in the role description for the restraint coordinator who is a RN. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Low | Assessment requirements are documented in restraint procedures. It identifies that the use of restraint and enablers require an assessment to be undertaken prior to approval being attained. The assessment sighted covers all aspects to cover the requirements of this criterion. The assessment sighted for the use of restraint in December 2015 was fully completed prior to approval. No assessment was undertaken for one episode of emergency restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA Moderate | Approved restraints are clearly documented. Policy identifies that restraint can only be applied as a last resort to maintain the safety of residents. Emergency restraint put in place did not meet policy requirements. The use of the emergency restraint is not recorded in restraint data recorded for quality review. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The one resident who had an approved restraint had this evaluated and as the desired outcome was not achieved the restraint was ceased. This is clearly indicated in documentation sighted. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | There was only one recorded restraint which was implemented six months ago, the quality review has yet to be completed. Management stated the overall review for restraint is not yet due as the facility has not been operating for one year. Individual restraint is reviewed by the restraint coordinator at three months and at the six monthly care update which is undertaken in the multidisciplinary team. |

# 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 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | PA Moderate | A general practitioner visits the service at least two times a week. The service has links with the local mental health services and palliative care services that reflect good practice. There is in-service education provided to staff and the staff can access external education that is focused on aged care and best practice. The residents and family/whanau expressed satisfaction with the care delivered.  The organisation has clinical policies and procedures and other reporting systems and supports that reflect good practice. However, these were not always implemented. The caregivers expressed that they have reported incidents (such as resident bruising) to the RNs and felt that this was not followed up (refer to 1.2.4). There was at least one instance in February 2016 of a suspected outbreak of nausea and vomiting, which had not been addressed through the required organisational reporting systems. An outbreak log was documented and found on the days of audit, though there is no evidence that this had been reported to the nurse manager, organisational clinical support team or external health services. The caregivers interviewed also recall another suspected outbreak in either the last week of November 2015 or the first week in December, though no records were sighted for this (refer to 3.5.7). The nurse manager does report an ‘open door’ policy and encourages staff to report issues or concerns, though the staff interviewed felt that if they have bought up issues, these are then not always followed up.  The service has guidelines on pressure injury management and the clinical assessment of the stages of pressure injuries. On two occasions there was evidence in the progress notes and by photograph, of suspected pressure injuries, though no other clinical interventions were documented or reported (refer to 1.2.4, 1.3.8.3). In one other instance a sacral ‘skin tear’ was classified in assessment as a stage 2 pressure injury and conflicting information on the incident form had the stage reported as a ‘level 1 pressure injury”.  Best practice was not evidenced in review of a resident requiring post-operative care for suture removal and treatment had not been provided in a timely manner (refer to 1.3.3.3). The progress notes of one resident recorded emergency restraint being used, without the required organisational processes being implemented (refer to 2.2.2 and 2.2.3). This is not reflective of best practice for behaviour management being implemented. | Not all policies and procedures are implemented. There is evidence of poor follow up of clinical practices such as not following post-operative advice, incomplete documentation of clinical findings and behaviour management. Caregivers concerns were not always evidenced as being followed up. For example, two separate reporting of residents with bruising to a registered nurse. This was confirmed during interview with RNs but no documentation could be found related to this. | Ensure staff are working in an environment which encourages good practice by following all documented policies and procedures.  90 days |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Moderate | There were some incidents and injuries that had not been reported through the organisational systems and therefore it was not able to establish if open disclosure has been maintained in these instances (also refer to 1.2.4.3). One instance of the use of emergency restraint is recorded in the progress notes and an update recorded on the restraint assessment form to contact the family about the use of the restraint during the night shift; however, there was no documented evidence that disclosing to the family or nurse manager had occurred. | As not all events are recorded as an incident or accident and not all events could be verified including family/whanau notification in the resident notes reviewed, open disclosure was not always evident. For example, the use of emergency restraint and two separate incidents of bruising had not been notified to the family/whanau or the nurse manager. | Provide evidence that all incidents and events are notified to the nominated next of kin.  90 days |
| Criterion 1.2.3.1  The organisation has a quality and risk management system which is understood and implemented by service providers. | PA High | The organisation has a quality and risk management system which is clearly documented but is not always implemented by service providers. For example:  Incidents and accidents are not always being documented using the organisational processes. This therefore does not allow the capture of data. Refer comments in 1.2.4.3.  Infection control reporting in the quality data sighted did not include all known infections. Refer comments in 3.5.7.  One assessment identified a stage two pressure injury but corresponding data showed this downgraded to a stage one and therefore was not captured in quality data. Refer comment 1.3.3.3.  Restraint reporting is not carried out accurately and the use of emergency restraint is not shown in the restraint register. Refer comment 2.2.1.  With the exception of one kitchen audit, the internal audit process as identified on the audit calendar has not been kept up to date. | The documented quality and risk management system is not always implemented by staff. The accuracy of data recorded could not be verified at the time of audit as inconsistencies were noted between what was evidenced in files and documentation and what was reported and recorded. For example, one resident with bruising on her hand had no incident form. An episode of diarrhoea and vomiting is not shown in quality data. Restraint reporting does not include the use of emergency restraint and a grade two pressure injury is not recorded. With the exception of one kitchen audit there have been no internal audit performed since January 2016. | Provide evidence that organisational quality and risk management systems are implemented by all service providers.  30 days |
| Criterion 1.2.3.5  Key components of service delivery shall be explicitly linked to the quality management system. | PA Moderate | Policy clearly indicates that the data collected related to the key components of service delivery are explicitly linked to the quality and risk management system. This includes complaints management, incident and accident reporting, infection control, health and safety and restraint. It was evident that not all data collected related to the key components of service delivery were accurately reported or recorded. Staff reported during interview two instances of residents with unexplained bruising which was reported to an RN. This could not be substantiated as no documentation could be found. Two RNs confirm the issues were reported to them by a caregiver. | Not all data required to inform the key components of service delivery are accurately recorded. Examples sighted relate to an assessment which showed a stage two pressure injury but documentation reporting showed this as a stage one pressure injury therefore not requiring to be reported in quality data. One approved restraint and one use of emergency restraint are not shown in the data sighted. Refer comments in 2.2.2 and 1.3.4.2 Reported unexplained bruising did not have a corresponding incident forms. Refer comment in 1.3.6.1 and 1.2.4.3. | Provide evidence that links to all key components of service delivery are reported and recorded.  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 | Quality improvement data are collected, analysed and evaluated and the results are communicated to staff at meetings. One quality improvement sighted for May 2016 identified that there were six interRAI assessments and five care plans overdue. The corrective actions were developed and being implemented at the time of audit. However, not all timeframes have been met. Refer comments 1.3.3.3.  This criterion is a low rating as there is evidence of data being used to improve services. However, as previously shown in this report not all events are accurately recorded such as unexplained bruising and no documented evidence was sighted related to the concerns being shared with family/whanau. | Quality improvement data collected is not a true reflection of clinical occurrences. RNs confirmed they did not write an incident form for two reports of resident bruising and in one resident file a photographed incident of bruising on a resident’s hand has not been recorded as an incident. It could not be verified that family/whanau had been notified. | Quality data information should be completed and recorded according to policy requirements.  180 days |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Moderate | The service has a documented process to measure achievement against the quality and risk management plan. Data collected is entered into an electronic system and is trended against previously collected data. At governance level this is benchmarked against other Metlifecare facilities and information is presented in graph form. This process should include the results of internal audits. However, with the exception of one kitchen audit, no audits had been undertaken since January 2016. Therefore, not all areas are being monitored to identify areas of concern. Not all clinical incidents are being recorded in a manner that allows data to be included in the measures required to identify achievements made. | The service cannot accurately measure achievement against quality and management processes owing to incomplete data recording. | Ensure all described processes are identified to measure achievements against the quality and risk management plan are implemented.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA High | Not all adverse or untoward events are documented. This was identified during interviews with staff who confirmed an incident form had not been completed related to two verbally reported incidents of unexplained resident bruising. Three of ten clinical files had photographs of bruising or suspected pressure injuries but no corresponding incident forms could be located for any of the events. Refer comments in criteria 1.3.3.6. | Two incidences of bruising reported to registered nurses by caregivers were not recorded on incident forms. One incident of bruising on a resident’s hand sighted in resident file did not have an incident form. This does not provide evidence that when incidents are reported they are followed up via a structured corrective action process to ensure the risk of recurrence or escalation of the issue is minimised or managed, because they are not reported in the first place. | Ensure all incidents and accidents are accurately recorded.  30 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is a generic organisational education calendar in place covering all aspects of care for a two-year period. The Orchards is completing education to match the requirements shown. Education sighted covers manual handling, grief and loss, syringe drivers, continence management, first aid, fire and emergency management, falls management, clinical skills including head to toe assessments for RNs and caregivers, and documentation. It is suggested that education related to wound care management to include correct pressure injury identification and incident and accident reporting be undertaken in the near future. The need for kitchen staff to attend food safety education has been identified by the village manager and signed acceptance for three kitchen staff onto an approved food safety course was sighted on the day of audit. | Only one member of the kitchen staff has attended a safe food handling course. | Provide evidence of kitchen staff education in relation to safe food handling.  180 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA High | Contractual time frames were not met for the completion of the initial assessment within 24 hours of admission in four of the ten files reviewed. In four of the ten files, one was dated the day of admission, but not fully completed, with three others not dated till five, eight and eleven days after admission.  Six files did not have an interRAI assessment completed within three weeks of admission. One of these files, of a resident receiving palliative care, does have a request noted from the needs assessment service not to complete. There were no other comprehensive organisational assessments completed in the interim. These overdue times frames ranged from 23 days to five months after admission.  Three files did not have a long term care plan that was developed within three weeks of admission or had a long term care plan in the resident’s file. The file that did not have the long term care plan had the file in the archived record, with this care plan dated six weeks after the admission date. The other two long term care plans were dated between six and eight weeks after admission. The service has identified the time frames as an area for improvement and has developed an action plan to address this. The action plan was signed off or fully implemented at the time of audit.  Timely interventions to meet the resident’s needs were sighted in at least two files (also refer to 1.3.6.1). One of the files reviewed contained post-operative instructions for the removal of sutures. This was not actioned till eight days after the advised removal date. The clinical staff were advised by the audit team of the overdue removal date on the first day of the audit and the removal was not actioned until the second day of audit.  One other file is of a resident with unexplained weight loss. This was first recorded in a short term care plan in January 2016 with a five-kilogram weight loss, no further recorded interventions were document until June 2016 after the resident had lost a further five kilograms. | Contractual timeframes for initial assessments/care plan, interRAI assessments and the development of the long term care plans were not evidenced in up to six of the ten residents’ files reviewed. The provision of clinical follow-up, such as the removal of sutures and interventions for unexplained weight loss were not conducted to meet best practice. This places residents at high risk of clinical complications. | Provide evidence that all timeframes are met and clinical interventions demonstrate best practice standards.  30 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Moderate | As identified in criterion 1.3.3.3 the incomplete clinical records and the follow up of clinical information and interventions (when not able to be implemented) are not contributing to ensuring that services are coordinated and the continuity of service delivery. It was not able to be ascertained if all relevant clinical information is effectively verbally passed on between shifts or passed onto the clinical manager, such as concerns with weight loss and the removal of sutures, caregiver concerns with resident bruises and the emergency use of restraint (also refer to 1.1.9.1 and 1.2.4.2). A team approach was not fully evidenced with the care staff reporting that the do not always feel if they pass information to the RN and/or nurse manager, that this will be actioned.  The follow through of information recorded in progress notes, short term care plans and wound treatment plans was not always evidenced as being actioned. Resident files had photos of residents’ skin, with no documented action of what was implemented for these concerns.  One file did not contain a care plan or behaviour management interventions. The lack of access to this plan did not promote service coordination or consistent interventions for their identified behaviours (this was the case for the resident that had an instance of emergency restraint used). | Documentation was incomplete related to clinical findings such as wound care management not being clearly described. One resident’s file did not contain a care plan and this was recovered from archives. It was not evidenced that there is effective communication with senior management and organisational management. | Provide evidence of actions taken that promotes continuity in service delivery.  90 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | In all ten residents’ files reviewed, not all of the needs were identified using the assessment process and this information is not always used as the basis for developing the care plan. Not all the assessment triggers from interRAI were captured in the care plan. Needs that were identified in the interRAI assessments, across the files reviewed, and not covered in the care plan, included delirium, risk factors such as tobacco and alcohol, communication, cognitive loss, continence and wandering. Where these triggers have not been included in the care plan, there is no record on the assessment summary as to why. In one file there was no interRAI assessment (at the request of NASC), no other organisational assessments are evidenced in this file.  Where it has been indicated that additional more in depth assessments are required, these were not evidenced in most instances. Five of the files made reference to assessing pain levels using pain assessment tools. Two residents who have had frequent falls did not evidence additional falls assessments or the organisational required post falls assessment. No assessments were undertaken for restraint and enabler use and one of two restraint approvals had no assessment undertaken. Challenging behaviour assessments, that identified triggers and de-escalation techniques were not sighted in two files where challenging behaviours were recorded. A resident with unexplained weight loss did have their diet requirements and likes and dislikes identified. | Ten of ten residents’ files did not contain comprehensive assessments on which to base care interventions. For example, clinical files do not always contain nutritional assessment, pain management, post-falls assessments, wound care, restraint/enablers, health risks and activities where these are indicated as being required. | Provide evidence that resident assessments are undertaken to meet policy and best practice requirements to ensure all residents’ needs are captured.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA High | In each if the files reviewed there was at least one need of the resident not fully evidencing that interventions had been implemented. Two of these files are at high risk of complications to the residents with post-operative instructions not fully followed and unexpected weight loss not evidencing timely interventions (also refer to 1.3.3.3 and 1.3.4.2). One of the files reviewed contained post-operative instructions for the removal of sutures on 21 June 2016. There is a progress note entry on 22 June 2016 that alternate sutures should be removed on ‘22 or 23’ June 2016. The wound treatment plan on 24 June 2016 records that the sutures were attempted to be removed on this date, but staff had been unable to do so, with a note stating that a blade to cut the sutures was ordered. There was no record that the sutures had been removed. On the date of audit, 28 June 2016 the manager and clinical staff were alerted by the auditors that there is no record of the sutures being removed. It was ascertained that the sutures had not yet been removed. The sutures were removed on 29 June 2016.  In a file of a resident with unexplained weight loss, there are monthly weighs of the resident. Four months after the resident’s admission their weight had reduced by five kilograms (9% of their body weight). A short term care plan was commenced in January 2016, which identified that the weight loss was an issue. There are no other interventions recorded in the short term care plan until June 2016, when the resident has lost a further five kilograms (which in total is a loss of 18.23% of their body weight in the eight months since admission). The nurse manager and clinical staff reported that there is no explained reason for this weight loss (such as a terminal disease). The file records that a request for specialist food supplements was approved in April 2016, though this is not updated on the long term or short term care plans. The nutritional care plan records on 4 May 2016 that the resident should be referred to a dietitian. The referral to a dietitian was not actioned until 24 June 2016 and review by the dietitian occurred on 29 June 2016.  The interventions implemented to assist in reducing falls were not clearly documented in two residents’ files who have had frequent falls. It was not clear what strategies were implemented for these residents who were prone to wandering and did not have the insight to use the call bell.  There were no documented strategies for the management of wandering and challenging behaviours for a resident with these documented behaviours, with an episode of restraint used on at least one documented occasion. In an episode of a resident with challenging behaviours, it was observed during the audit that staff did not respond to the resident. When staff were alerted that the resident required assistance, one response was that the RN had just given them their medication. At this time, it was observed three caregivers were in a lounge area where there were no residents.  In five of the residents’ files reviewed, pain had been identified as an issue. It was not clearly identified if the interventions had the desired effects, as these were not always recorded.  Two of the files had a notation ‘reddened skin’ identified in the progress notes or through photographs; the interventions implemented for these residents were not recorded. | Required interventions to meet residents’ needs are not always completed or clearly identified. This was evident in 10 of 10 files reviewed and relates to pain management, post-operative follow-up, post falls management, wound care, challenging behaviour, weight loss and pressure injury management. | Provide evidence that service provision interventions are completed and consistent to ensure residents’ needs are met.  30 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | The residents report that they have the opportunity to participate in meaningful activities at the care facility. Two of the residents interviewed preferred to entertain themselves in their room over joining in on any of the other planned activities. There is an activities coordinator Monday to Friday with family time encouraged over the weekends. The activities coordinator reported they are in the process of conducting the activities assessments for each of the residents. The activities assessments sighted in the files had been conducted within the last month (one in May 2016 and the remainder in June 2016). The activities coordinator reported that they have developed an interim programme (sighted), that covers physical, social, recreational and emotional needs of the residents until they complete the activities assessment and know what is meaningful to each of the residents. In the activities that they have provided over the previous week, the activities coordinator reports that they have gauged the response of residents during activities and modified the programme related to the resident’s abilities and interests. They report they have already modified some of the activities according to the capability and cognitive abilities of the residents.  The March 2016 satisfaction survey records a 75% satisfaction response to the activities provided at The Orchards, this is below the Metlifecare national average of 85% satisfaction. The service has commenced making improvements to the activities programme with the newly appointed activities coordinator. | There was no documented evidence that planned activities were being provided until June 2016. Interviews with residents and management confirmed activities were provided. No individual resident activities assessments were sighted prior to May 2016. | Ensure planned activities are provided and documented to meet residents’ strengths and skills.  180 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | Short term changes to the resident’s condition was not always fully captured in the documentation. Four of the short term care plans that had been developed (two for skin care, one for pain management and one for weight loss), did not evidence any ongoing interventions or monitoring or evaluation. Two other files had photos of changes to skin condition, with no other assessment or short term care plan as to the interventions that were implemented. | Short term care plans were not developed, or when developed not followed through, for all issues identified. Such as management of wounds, skin care/pressure injury, pain management and weight loss. This was identified in six of the ten files reviewed. | Provide evidence where progress is different from expected that the short term care plans are developed and acted upon in a timely manner.  90 days |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | PA Low | The infection data reviewed for 2016 recorded the collation, analysis, graphing and trending of some of the infection data. The analysis includes the reasons for any increase or decrease in the number and types of infections. The outcomes are fed back to the staff at the next staff meeting and displayed on the staff notice board. Though there was some analysis of the data, the data did not contain all infections. The care staff reported there was an outbreak of nausea and vomiting in February 2016, this was not evidenced in the infection data reported to the Metlifecare organisational management or essential notifications (also refer to 1.2.4.2). An outbreak log sheet was sighted for this, though the data had not been reported in the monthly infection surveillance reports. There was no information provided at the time of audit as to why the information was not recorded in the infection data or documented evidence as why the infections were not classified as an outbreak. Even though it may not have been an outbreak,the individual resident infection (for example the 24-hour period of gastroenteritis) was not recorded in the infection data. The care staff also reported that they recalled another outbreak in either the end of November 2015 or the first week in December 2015, though there was no documented evidence found for this alleged outbreak. | The infection control quality data collected did not include all known infections. | Provide evidence that surveillance data includes all infection control events.  180 days |
| Criterion 2.2.2.1  In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to: (a) Any risks related to the use of restraint; (b) Any underlying causes for the relevant behaviour or condition if known; (c) Existing advance directives the consumer may have made; (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes; (e) Any history of trauma or abuse, which may have involved the consumer being held against their will; (f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies. | PA Low | One resident who had a previously approved lap belt restraint had a fully completed assessment. When restraint was stopped documentation clearly identified that this was ceased as it was “causing (the resident) agitation leading to more risk than safety”. The lap belt was not applied every day but only when staff felt it was required and it was assessed and approved on 21 December 2015 and ceased on 10 March 2016. (This is the resident who had emergency restraint applied in May 2016 which was not reported).  Emergency restraint was used for a resident as identified during the file reviews but no assessments were undertaken either pre or post restraint use. This was a one off incident. Refer to comments in 1.3.4.2. Another file showed that bedside rails were signed for by the family/whanau as an approved restraint. There is no assessment for this restraint. Discussions with a RN confirmed that the bedside rails were never placed on the bed as they were not available. However, the bed is pushed up against the bedroom wall and staff stated this was done upon the resident’s request and therefore staff believe it is an enabler. The nurse manager confirmed bedside rails are available. | No assessments were undertaken for a resident who required emergency restraint. An approved restraint in another resident’s file is signed by family/whanau but no assessments could be located. As observed, the bedside rails were not on the resident’s bed at the time of audit. | Provide evidence that all restraint assessments are completed to meet requirements.  180 days |
| Criterion 2.2.3.2  Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made: (a) Only as a last resort to maintain the safety of consumers, service providers or others; (b) Following appropriate planning and preparation; (c) By the most appropriate health professional; (d) When the environment is appropriate and safe for successful initiation; (e) When adequate resources are assembled to ensure safe initiation. | PA Moderate | There are clearly documented approved restraints. They include bedside rails and lap belts which are the only two approved restraints sighted. Policy clearly identifies that restraint is only to be used as a last resort and all the required standard requirements are documented. Policy was not followed for an episode of emergency restraint documented in a resident’s file. The restraint was applied as the resident was wandering around and calling out. | Emergency restraint was used for a resident in May 2016 who was awake during the night. The resident had previous restraint approval which according to documentation sighted in the file was ceased in March 2016 owing to it causing agitation. The reason for the use of emergency restraint was to manage agitation and does not meet policy requirements as neither the resident nor others were at risk of injury. Documentation related to this incident is incomplete and it has not been recorded in restraint data sighted. Refer comments in section 1.2.3. | Ensure all restraint process and approval requirements are clearly documented and meet policy and safe restraint use requirements.  90 days |
| Criterion 2.2.3.4  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. | PA Low | Policy identifies the need to document in sufficient detail the use, duration and outcome of any restraint events. The one approved restraint shown in the restraint register has a four-day post evaluation which is well documented along with a full review and evaluation at 10 weeks. This review was conducted as it had been identified that the restraint was not preventing any risk to the resident but only making them more agitated. (The lap belt was never used for more than 2.5 hours per day). Restraint use ceased in March 2016.  Evaluation could not be evidenced for the use of emergency restraint. A small note was written on the bottom of a previously approved restraint document for the resident that it had been used. The document clearly indicated that this was no longer valid. This was not reported to management.  There was no ongoing reporting of the event so this information did not get entered into the restraint register or into quality and risk reportable data. Refer comments in standard 1.2.3. | When emergency restraint was implemented in May 2016 the resident’s progress notes stated the resident was to be monitored closely. No timeframes were shown. The outcome of the restraint is not recorded. There are no details of alternative interventions being used. | Ensure that each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration and outcome.  180 days |
| Criterion 2.2.3.5  A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use. | PA Low | The only entry sighted in the restraint register is one restraint which is no longer in use.  It was discussed that the restraint register could be reworded in places to make it an easier, more auditable tool. This was actioned on the day of audit and has been sent to head office for approval. | The restraint register sighted does not show the use of emergency restraint as this was not reported to management at the time and was not included in data collection. | Ensure all restraint use is clearly recorded.  180 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.