

Metlifecare Limited - Palmerston North

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Metlifecare Limited
Premises audited:	Metlifecare Palmerston North
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 November 2016 End date: 16 November 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:	39

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Metlifecare Palmerston North is one of over 20 facilities owned and operated by the Metlifecare group. Metlifecare Palmerston North provides rest home and hospital level care for up to 43 residents. The service has 38 beds in the care unit which can be used for either hospital or rest home level care and five village apartments which are approved for rest home level care only.

This surveillance 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 organisational documentation, staff files and residents' clinical files, observations, and interviews with residents, families/whānau, management, staff and a general practitioner. The clinical quality and risk manager from Metlifecare Limited was also present on the day of audit.

Feedback from residents and families/whānau members was positive about the care and services provided.

This audit has resulted in two criteria which have gained a higher than usual rating. Continuous improvement ratings are related to quality data and follow-up of corrective actions. There were six criteria which were identified for improvement in the previous certification audit and five have been fully addressed. The sixth area related to service delivery plans, whilst showing improvement, requires further development around ensuring consistency in the development of short term care plans.

Consumer rights

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

Residents and family/whanau receive full and frank information and open disclosure from staff. The resident, their families or enduring power of attorneys (EPOAs) are involved in the care planning, decision making and consent processes. Where there is a valid advance directive, the staff act on the decisions.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
---	--	--

Metlifecare Limited's governing body ensures that business and strategic planning is in place to cover all aspects of service delivery. This is reviewed and updated annually. Metlifecare Palmerston North has an annual business plan which is personalised to the services offered at the facility with strategic goals which enhance the organisational direction. Quarterly reporting against the business plan and monthly management reports inform head office of progress with each goal. The nurse manager is responsible for the overall management of the care facility services. The nurse manager who has worked at Metlifecare Palmerston North for over 12 years is supported by a senior clinical nurse and a team of registered nurses. All staff receive appropriate education for the roles they undertake.

At organisational level there is a clinical governance group to oversee any issues that occur and to provide oversight of all major clinical projects. At facility level, the quality and risk system and processes support effective, timely service delivery. Corrective action planning is implemented to manage any 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.

There is no resident information accessible to the public.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care staff, and a number of general practitioners. On call arrangements for support from senior staff are in place. Shift handovers, communication sheets and the updating of residents' progress notes each shift guide continuity of care.

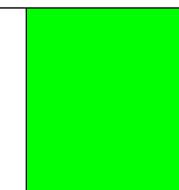
Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are generally developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular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

The planned activity programme, overseen by an experienced diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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

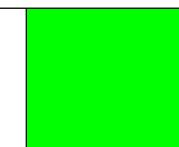
The food service meets the nutritional needs of the residents with special needs catered for. Policies and procedures guide food service delivery, supported by staff with appropriate food safety qualifications. The kitchen was well organised, clean and meets food safety standards.

Safe and appropriate environment

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

The care facility has a current building warrant of fitness. The resident call bell system is checked six monthly to meet policy requirements.

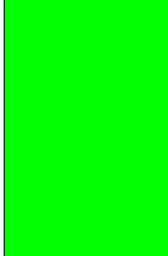
Restraint minimisation and safe practice

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

Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. At the time of audit there is no restraint or enablers in use. Restraint approval and assessment

processes are known to staff. Staff undertake education related to restraint minimisation and they have a clear understanding of the difference between enablers and restraints and how to safely manage both.

Infection prevention and control

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

There is a systematic and comprehensive approach to infection surveillance. Surveillance data is collected, analysed, trended and benchmarked. Results are reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	18	0	0	1	0	0
Criteria	2	39	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Metlifecare Palmerston North implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system. All complaints are registered at Metlifecare head office electronically. 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. These are located outside the Garden Lounge.</p> <p>The service has a complaint register which identifies the nature of the complaint, the date received and the actions taken to address the complaint. Documented complaints information is used to improve services as appropriate. Complaints are a standing agenda item for all meetings including management and staff meetings as confirmed in meeting minutes sighted. All complaints have been managed at a facility level since the previous audit.</p> <p>There were no outstanding complaints at the time of audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Staff education has been provided related to appropriate communication methods and staff confirmed during interview they report all concerns. Family/whanau and resident interviews confirmed they are well informed by staff. The service has not required access to interpreting services for the residents and at the time of audit there are no residents with English as a second language. Information to access approved</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>interpreter services is available to all staff and policies and procedures guide staff actions. Documentation of open disclosure following incidents/accidents was evident. The services use an electronic reporting system which prompts staff to ensure family/whanau notification is made.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The organisation's philosophy, mission statement and values are clearly documented. Metlifecare Palmerston North has a personalised business plan which is in line with the direction and objectives of the organising body as identified in the organisation's operating plan and five-year strategic vision plan. The business plan identifies how services are planned to address residents' needs. Documented annual goals are reported against quarterly by the nurse manager to the organisation's board of trustees. The nurse manager's monthly report includes quality data information.</p> <p>On the day of audit there were 25 hospital and 14 rest home level care beds occupied. Two of the rest home level care residents own their own apartments under an occupational right agreement but have age related care services which are approved by the district health board.</p> <p>The care facility is managed by a nurse manager who has been in the role for many years and she holds a current annual practising certificate as a registered nurse. A team of registered nurses supports the nurse manager, all of whom maintain appropriate education and qualifications for the roles they undertake. The clinical quality and risk manager represented the Metlifecare organisation on the day of audit.</p> <p>Interviews with residents and family/whānau confirmed that the service meets their needs. The resident satisfaction survey results show that for the 2016 resident satisfaction survey results gained an 89% rating for overall satisfaction with services provided. No negative comments were received during interviews with family/whānau, residents or staff on the days of audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The service has a quality and risk management system which was understood and implemented by service providers. This includes the development and update of policies and procedures at organisational level, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Following a quality project, the facility is now restraint free.</p> <p>The annual operating plan for Metlifecare Palmerston North includes quality objectives with progressive measurement processes identified. Quality data collected are analysed at facility and governance level. Data analysis is discussed and viewed at clinical governance level and by the organisational clinical management team. Quality data results are trended against previously collected data and the other Metlifecare care units. Infection control, falls, urinary tract infections, pressure injuries and restraint use and psychotropic medications use are also benchmarked by an off-site company against other like community facilities and reports are generated quarterly.</p>

		<p>Quality data results are shared at all levels of the organisation including at the monthly staff meetings. At facility level this information is used to inform ongoing planning of services to ensure residents' needs are met. If an issue or deficit is found a corrective action is put in place to address the situation. This is verified in meeting minutes sighted and by staff during interviews.</p> <p>Quality data analysis processes and corrective action planning are shown to generate projects which are clearly documented. The service achievement of both the before mentioned areas are rated beyond the expected fully attainment as resident safety or satisfaction has been measured and shows positive results have been achieved.</p> <p>Actual and potential risks are identified and documented in the hazard register and in the quality and risk plan. All known risks are evaluated each year at governance level and the risk register is updated. Newly found hazards at the care facility 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 committee meetings and any required follow up is monitored. New hazards are also alerted to head office via an electronic risk management system.</p> <p>Staff, resident and family/whānau interviews confirmed any concerns had been fully addressed by management. Quality improvements are documented and the corrective action process can be followed from the time an issue is recognised until it is implemented, reviewed, outcome evaluated and closed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Adverse event reporting as identified in policy, is implemented by the service. The nurse manager confirmed her awareness of the organisation's requirement related to statutory and or/regulatory reporting obligations including pressure injury reporting to meet documented protocol. One example of reporting an adverse event related to a gastro outbreak of no confirmed know origin in May 2016. All authorities were notified.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information was 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 documentation sighted. All incident and accident forms are reviewed by the nurse manager.</p> <p>Interviews and documentation sighted confirmed family/whānau are notified of any adverse events or concerns staff have about residents. This process is aided by the electronic reporting system which is in place that prompts staff to remind them this is a requirement.</p> <p>Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. (Refer comments in criteria 1.2.3.8).</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. This is reflected in the six staff files reviewed. All roles have job descriptions that describe staff responsibilities and accountability. Staff complete an orientation programme with specific competencies for their roles. Each file reviewed had completed orientation/competency booklets and up to date annual appraisals. Documentation in the staff files reviewed confirmed some competencies, such as medication management are repeated annually. Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis.</p> <p>The education calendar sighted identifies that staff undertake training and education related to their roles. Topics covered in annual training and education relates to age care and health care services. The education calendar is set at head office and Metlifecare Palmerston North add additional items as required to ensure staff interests and needs are met. Education occurs both on and off site.</p> <p>Resident and family/whānau members interviewed, identified that services are delivered in a professional manner to meet all their needs.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>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 to provide safe and quality care.</p> <p>Staffing numbers are analysed at head office to ensure the number of staff on each shift is adequate to meet residents' needs depending on care levels.</p> <p>A review of four weeks' 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 to meet residents' needs. There is a registered nurse of every shift. Residents interviewed stated all their needs have been met in a timely manner.</p> <p>The nurse manager works five days a week and the senior registered nurse works five days a week to oversee all clinical activity. There are dedicated activity, reception, cleaning, and laundry staff. The night shift carries two caregivers and one registered nurse. One of the caregivers responds to emergency call bells for village residents. Staff report the registered nurse does not leave the facility.</p> <p>Three of the eight registered nurses hold current interRAI competencies.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	FA	<p>Health information was kept in secure areas in the staff area and these were not accessible or observable</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>to the public. There was no private information on display in the facility.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. Medication administration records confirmed that medications were administered as prescribed. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.</p> <p>There was one resident who self-administered medications at the time of audit. Comprehensive processes are in place to ensure this is managed in a safe manner.</p> <p>Standing orders are not used by the service.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food,</p>	<p>FA</p>	<p>The food service is provided on site by a kitchen team led by an experienced kitchen manager and is in line with recognised nutritional guidelines for older people. A new menu, which follows an eight-week cycle and has been reviewed by a registered dietician is just about to be implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal</p>

<p>fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>comply with current legislation and guidelines. Food temperatures are monitored appropriately and recorded as part of the plan. The kitchen manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>A resident satisfaction survey completed in September 2016 identified a 58% satisfaction rate with food services. The service has instigated a comprehensive action plan to improve satisfaction with meals. This includes a full menu review by a registered dietician and the appointment at group level of a food adviser with many years' industry experience and appropriate qualifications. Re-auditing of resident satisfaction with food services will be undertaken in three months. All residents interviewed during the audit stated that they enjoyed the meals, and that they were offered alternative options if they did not like something that was on the menu.</p> <p>There is sufficient staff on duty in the two dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>With the exception of wound management, the care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress notes, activities notes, medical orders, and were clearly written, informative and relevant. Any change in care required is documented and the senior registered nurse advised these were then verbally passed on to relevant staff. Residents reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>A general practitioner who regularly visit the facility confirmed that the provision of care for residents was consistent with their needs and goals, and confirmed their satisfaction with the standard of care. They reported that they were advised in a timely manner of any changes in a resident's clinical condition, and that their prescribed treatments were followed. Care plans included detailed strategies to guide care delivery staff. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs. All residents interviewed advised they were satisfied with service provision.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by a full-time qualified and experienced diversional therapist.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated monthly and as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include regular outings, crafts, gardening, word games, bowls and housie, knit and natter groups, exercises, church services and entertainment. The activities programme is discussed at the regular residents' meetings and residents' input is sought and responded to. Residents interviewed confirmed they find the programme interesting and engaging.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal and detailed care plan evaluations occur at least every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. The RN documents evaluations. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans had been reviewed within appropriate time frames, and progress evaluated. Residents interviewed provided examples of involvement in evaluation of progress and any resulting changes</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>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 31 August 2017. There is an approved fire evacuation for the facility.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p>	<p>FA</p>	<p>Resident call bells are located in all resident areas. Resident and family/whānau interviews confirmed call bells were answered in an acceptable timeframe. Call bells are checked six monthly and dates sighted were 29 April 2016 and 07 October 2016.</p>

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		
<p>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.</p>	<p>FA</p>	<p>Well-established and comprehensive systems are in place to monitor infections. Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, eyes, gastro-intestinal and respiratory tract. When an infection is identified, a record of this is documented in the group's electronic resident management system. The infection control coordinator reviews all reported infections. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. The service operates two systems for this – a monthly evaluation against other facilities within the group, and an external benchmarking system which reports results against like facilities. Results are reported to the facility manager, reported at group level, and reported to the facility's health and safety committee. Surveillance results are also shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes sighted and interviews with staff. See also criterion 1.2.3.6.</p> <p>A summary report for gastrointestinal infection outbreak earlier in the year was reviewed and demonstrated a thorough process for investigation and follow up.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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 safe use of restraint.</p> <p>The service has managed to gain a restraint free environment and had no restraints or enablers in use at the time of audit. (Refer comments in criterion 1.2.3.6). Clinical staff undertake annual restraint minimisation education. Staff are required to complete a written competency related to the safe and correct use of restraint should it be required. Staff verbalised their knowledge and understanding of safe restraint use.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>A previous corrective action from the certification identified that service delivery plans do not fully describe the support a resident requires to meet their needs.</p> <p>Registered nurses are responsible for the development of each individualised plan for care, and for the ongoing evaluation and review process. Initially five clinical files were reviewed, and comprehensive long-term care plans had been developed for all these residents. With one exception, these plans reflected all care requirements. Examples were sighted of short term care plans being developed as clinically indicated, and then reviewed in a timely manner.</p> <p>Following a review of the documentation related to two wounds, the file sample size was expanded to include another six residents whose names appeared on the current wounds register. The assessment of these wounds, and the documentation related to wound treatment was mostly comprehensive. Five of these residents had no short-term care plan related to their wound; the wound treatment record of two residents did not include the date on which the wound should next be reviewed, and</p>	<p>Short term care plans are not consistently developed for residents in relation to wound care.</p>	<p>Service delivery plans describe the required supports and/or interventions.</p> <p>90 days</p>

		in three instances there was no evidence that the last scheduled wound review had taken place.		
--	--	--	--	--

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Quality data is collected to meet all key components of service delivery. This data is trended against other Metlifecare facilities and previously collected data monthly. It is reviewed at governance, management, and facility level. Clinical data is also benchmarked by an independent, off-site provider against other like facilities in the community and reported against three monthly. The clinical quality and risk manager, who monitors all data, gains regular reports, and assists with projects to ensure any major rise in reported quality data is fully addressed. Examples sighted relate to corrective actions being put in place as a result of the resident satisfaction survey results showing a 53% rating for the quality of meals, responding to staff satisfaction engagement results which highlighted staff dissatisfaction with their staff room, and follow up of medication audit results. Positive outcomes have been gained by Metlifecare engaging a dedicated staff member employed to oversee and improve all food services, a dietitian was involved in review of menus and on the day of audit no negative comments were made about food services. Internal audits show overall resident satisfaction. Staff now have a refurbished staff room which they are very happy with. Medication errors have decreased following intensive ongoing staff education.</p> <p>Each quality issue is documented to show what the issue found was, how it was to be addressed,</p>	<p>The service can demonstrate that all quality and risk data collected is analysed and evaluated. Evaluated data is used to make improvements to services by ensuring issues found are followed up and clearly documented. Outcomes are measurable and identify how residents, visitors and staff benefit from</p>

		<p>who was responsible for follow up, re-evaluation and the success of the outcome prior to being signed off. The project related to the facility becoming restraint free (which is yet to be fully evaluated) identifies that residents and family/whanau were fully informed of how this would happen and how the risk was to be managed. It also involved discussion with key staff from the public hospital when resident discharge was being arranged prior to entry to the facility to ensure family/whanau and residents were made aware that alternative techniques are trialled rather than restraint. This project to date has resulted in a restraint free environment compared to 18 restraints (12 restraints and six enabler) the same time last year.</p>	<p>improvements put in place.</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>CI</p>	<p>The achievement of the depth to which corrective action planning is addressed at Metlifecare Palmerston North is rated beyond the expected fully attainment. The corrective action plans sighted show each step of the process and measurable outcomes to improve service delivery. For example, in August 2016 an internal audit identified that not all staff were not documenting why pro re nata (PRN) medication was being given or the effectiveness of the medication. It gained a 96% result. Following staff education and senior staff mentoring the medication audit gained a 100% audit result in September and November 2016. Other examples of audit result follow up shows that this is embedded into practice and that outcome measures have improved the way services are delivered and resident safety.</p>	<p>The service can demonstrate consistent measured follow up documented in corrective action planning reflects current best practice and is undertaken within set timelines. Results sighted identify changes made to some aspects of service delivery and staff awareness ensure a safer environment for residents.</p>

End of the report.