# Age Care Central Limited - Maryann Rest Home and Hospital

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

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

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

The specifics of this audit included:

**Legal entity:** Age Care Central Limited

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

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

**Dates of audit:** Start date: 21 February 2017 End date: 22 February 2017

**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 |
|  | 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

Maryann Rest Home provides rest home, hospital and dementia level of care for up to 48 residents. On the day of the audit there were 39 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

The service is overseen by a chief executive officer, and is managed by a nurse manager and a clinical manager and one domestic services supervisor. The residents and relatives interviewed all spoke positively about the care and support provided.

This certification audit identified that improvements are required in relation to advanced directives, the internal audit programme, corrective action plans, education and training, care interventions, risks associated with restraints, and restraint evaluations.

## 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 low risk. |

The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Residents and family report communication with management and staff is open and transparent. Complaints and concerns are being managed and a complaints register is maintained.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Services are planned, coordinated, and are appropriate to the needs of the residents. Quality goals are documented and regularly reviewed. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. The health and safety programme meets current legislative requirements. Adverse, unplanned and untoward events are documented and investigated. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is being implemented. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents’ files are appropriate to the service type.

## Continuum of service delivery

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

There is comprehensive service information made available to residents and families. Assessments, care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans are written in a way that enables all staff to clearly follow their instructions. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options can be provided. Residents and relatives interviewed were complimentary about the food service.

## 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. |

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility.

All bedrooms are single occupancy and some have their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas. The internal areas can be ventilated and heated. The outdoor areas are safe and easily accessible and the dementia garden is secure. Cleaning and laundry staff are providing appropriate services.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

## 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 low risk. |

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint coordinator is a registered nurse. There were five residents with cot side only restraints and no residents using and enabler.

## Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to residents, staff and visitors. The infection control programme is implemented, meets the needs of the service and provides information and resources to inform the staff. Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the service. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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 | 44 | 0 | 6 | 0 | 0 | 0 |
| **Criteria** | 0 | 94 | 0 | 7 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Code of Health and Disability Consumers’ Rights (the Code) brochures are provided to residents and their families. Policy relating to the Code is implemented. Four managers (one clinical manager, one nurse manager, one clinical coordinator, one domestic services manager), and seven care staff (three caregivers, three registered nurses (RN), one activities coordinator) interviewed confirmed their understanding of the Code and provided examples of how the Code is applied to residents’ cares. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | Informed consent processes are discussed with residents and families on admission. Written consents are signed by the resident or their enduring power of attorney (EPOA). Advanced directives are signed for separately. Not all advance directives in the sample of resident files were valid. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives.  All seven resident files sampled had signed admission agreements and consents. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | HDC advocacy brochures are included in the information provided to new residents and their family during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services.  Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. |
| 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 | The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages their residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. Interviews with the rest home level residents confirmed that they are encouraged to remain active in their community and participate in social activities external to the aged care facility. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. A record of all complaints received is maintained. Five complaints were received in 2016 and one in 2017 (year to date). Documentation including follow-up letters and resolution demonstrated that complaints are well-managed. Discussions with residents and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. Staff discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings. All seven residents (five rest home level and two hospital level and seven family (four hospital level and three dementia level) interviewed reported that the residents’ rights were being upheld by 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 | The residents’ personal belongings are used to decorate their rooms. Privacy signage is on communal toilet doors.  The care staff interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All of the residents and families interviewed confirmed that the residents’ privacy is respected.  Guidelines on abuse and neglect are documented in policy. Staff attend mandatory education and training on abuse and neglect, which begins during their induction to the service. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. Links are established with the local marae and a cultural advisor from the district health board. One board member identifies as Māori.  Staff education on cultural awareness begins during their induction to the service and continues as a regular inservice. The caregivers interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service. There were three residents living at the facility who identified as Māori during the audit but were unable to be interviewed. |
| 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 service identifies the residents’ personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents’ care plans, evidenced in all seven care plans reviewed (two rest home, three dementia and two hospital). Residents and family interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Good practice was evident. A registered nurse is on site 24 hours a day, seven days a week. A general practitioner (GP) visits the facility once a week. Residents are reviewed by a general practitioner (GP) every three months at a minimum.  Residents and family/whānau interviewed reported that they are either satisfied or very satisfied with the services received. A resident/family satisfaction survey is completed annually and confirmed satisfaction with the services received.  The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits. Physiotherapy services are available on an as needed basis through the district health board. A van is on site for regular outings. The kitchen has recently been refurbished. The dementia unit, on the ground level, is linked to a landscaped outdoor area with flower gardens and numerous places to sit and enjoy the outdoors.  The GP interviewed is satisfied with the care that is being provided by the service. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required.  Families interviewed confirmed they are kept informed of the resident`s status, including any events adversely affecting the resident. Fifteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.  An interpreter service is available and accessible if required through the DHB. Families and staff are utilised in the first instance. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Aged Care Central Limited is a company formed to manage the operations of Maryann Rest Home and one other aged care facility in Stratford. It is registered as a charitable entity under the Charities Act.  Maryann Rest Home provides care for up to 48 residents at rest home, dementia and hospital (medical and geriatric) level of care. Two beds in the dementia unit can swing to hospital level care (they have two sets of lockable doors that can be changed as needed). One room that was going to be converted to a dementia level room (link to HealthCERT approval letter for reconfiguration of services dated 18 Sept 2015) is being used as a sensory room instead.  At the time of the audit, there were 39 residents. This included 14 residents at dementia level, 9 at rest home level and 16 at hospital level. Two residents were on the young persons with disability contract (one dementia, one hospital). There are no designated dual-purpose beds in the rest home wing.  A mission statement, philosophy and goals have been determined. A chief executive officer (CEO) reports to a board of directors. He has a background in radiography and is also the mayor of Stratford. Two managers/RNs are responsible for clinical operations (one clinical manager and one nurse manager) and one manager is responsible for domestic operations (eg, kitchen, cleaning, laundry, maintenance). Goals are regularly reviewed in the manager meetings and board meetings (evidenced in the meeting minutes).  The CEO and managers have maintained at least eight hours annually of professional development activities related to managing an aged care facility within their scope of responsibilities. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The clinical manager and the nurse manager share clinical responsibilities and cover for each other when one is absent. A designated staff member is responsible for domestic operations in the absence of the domestic services manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | A quality and risk management programme is in place. Interviews with the chief executive officer, managers, care staff and domestic staff (one cook, one maintenance, one cleaner) reflected their understanding of the quality and risk management systems that have been put into place.  Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to InterRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.  Quality data collected is collated and analysed with results communicated to staff, but meetings are held infrequently and results were not posted in the staff room for staff to view. An internal audit programme is established but the completion of audits was behind schedule. Areas of non-compliance include the initiation of a corrective action plan but corrective actions are not routinely signed off to evidence their implementation.  A health and safety programme is in place that meets current legislative requirements. An interview with two health and safety representatives and the health and safety officer (domestic services manager) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors are orientated to the facility’s health and safety programme. Hazards registers are in place for each area and are regularly reviewed.  Falls prevention strategies include a comprehensive investigation of residents’ falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. Sensor mats and lipped mattresses have assisted in reducing the number of falls. Hip protectors are used to prevent injuries from falls. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | An accidents and incidents reporting policy is in place. There was evidence to support actions are undertaken to minimise the number of incidents. Clinical evaluation of residents following an adverse event is conducted by a registered nurse and was evidenced in all fifteen accident/incident forms selected for review.  Adverse events are linked to the quality and risk management programme. Missing was evidence of staff being informed in a timely manner regarding accidents and incidents and the implementation of corrective actions (where applicable) to reduce the number of adverse events (link 1.2.3.6 and 1.2.3.8).  Discussions with the managers confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| 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 | There are human resource management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications, experience and veracity, evidenced in all eight staff files reviewed (four caregivers, four registered nurses).  Copies of practising certificates are kept on file. The service has implemented a general orientation programme that provides new staff with relevant information for safe work practice. Evidence of completed induction checklists were sighted. Annual staff appraisals sighted were up-to-date.  An in-service education programme is being implemented. Regular in-services are provided by a range of in-house and external speakers including but not limited to nurse specialists, Aged Concern and the Health and Disability Advocacy Service. Two caregivers who work regularly in the dementia unit have not completed the New Zealand Qualification Authority (NZQA) dementia unit standards. There are four InterRAI trained nurses. All RNs are first aid trained and have completed syringe driver competencies. |
| 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 includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. A clinical manager/RN and nurse manage/RN work five and four days a week respectively.  The rest home wing (eight residents) is staffed with one caregiver on each shift. This caregiver also assists on the hospital level wing if needed. The hospital wing (16 residents) is staffed with an RN on each shift who is assisted by two caregivers on the am and pm shifts and one caregiver on the night shift. The dementia unit (14 residents) is staffed with two caregivers on the am and pm shifts and one caregiver on the night shift. Extra staff can be called on for increased resident requirements.  Activities staff are rostered seven days a week. There are separate domestic staff who are responsible for cleaning and laundry services.  Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked area. All electronic data is backed up securely using cloud-based technology.  Residents’ files demonstrate service integration. Entries are legible, dated, timed and signed by the carer, and includes their designation. |
| 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 service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical manager or nurse manager screen all potential residents prior to entry and record all admission enquires. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed was signed as administered on the electronic signing charts sampled. Registered nurses and senior caregivers administer medicines. All staff that administer medication have been assessed as competent and have received medication management training. The facility uses a blister pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. The 14 electronic medication charts sampled were written correctly by medical practitioners and there was evidence of three monthly reviews by the GP. There were no residents self-administering medicines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a fully functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the cook works closely with the RNs on duty. The kitchen staff have completed food safety training. The cook follows a rotating seasonal menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments were completed and were reviewed at least six monthly or when there was a change to a resident’s health condition in files sampled. Areas triggered in the InterRAI assessment then had a more comprehensive assessment completed in the electronic database and the information from these assessments automatically populates the individualised long-term care plan (link 1.3.6.1). Care plans reviewed were developed based on these assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The electronic long-term care plans reviewed described the support required to meet the resident’s goals and needs except behaviour management (link 1.3.6.1) and identified allied health involvement under a comprehensive range of template headings. Residents and their family/whānau are involved in the care planning and review process. Electronic short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Registered nurses (RNs) and caregivers follow the electronic care plan and report progress against the care plan each shift. Care plans are developed automatically following a set of personalised assessments and the update of these on the electronic database. Interventions to manage behaviours were not documented in the system but all other identified areas of need were. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.  Wound assessment, monitoring and wound management plans are in place for nine residents with wounds – eight skin tears and one fungating skin cancer. There were no pressure injuries at the time of the audit. One resident had combined documentation for two wounds. Three had not been documented as reviewed when required.  The RNs have access to specialist nursing wound care management advice through the gerontology nurse specialist and the one chronic wound had received input from this service.  Care plan interventions including food and fluid charts, turning charts, weight monitoring and blood sugar recordings were sighted in the electronic database and demonstrated interventions to meet residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Two activities coordinators are employed four days per week each and every second weekend to coordinate the activities programme for all residents. They are supported by a diversional therapist in the dementia unit one day per week. Activities are provided seven days per week in the activities unit and are planned around residents’ interests, needs and abilities. Outside of the hours the activities coordinator are available suggested activities for each resident were documented in files sampled and staff engage residents in activities. A separate programme runs for residents in the rest home and hospital units. Each resident has an individual activities assessment on admission and from this information an individual activities plan is developed as part of the care plan by the registered nurses with input from the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan and significant time is dedicated to 1:1 activities. Participation is monitored in individual progress notes records. Group activities reflect ordinary patterns of life and include planned visits to the community. All resident files sampled have a recent activities plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Residents and families interviewed commented positively on the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In files sampled, all initial care plans were evaluated by the registered nurses within three weeks of admission. The long-term care plans reviewed were evaluated at least six monthly or earlier if there was a change in health status. There is at least a three-monthly review by the GP. All changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident’s condition had changed and the resident was reassessed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness. The building has a number of alcoves and lounge areas in each unit. Maintenance is coordinated by the domestic services manager who has two staff to complete handyman type tasks across this and another site and who engages contractors as required, ensuring reactive and planned maintenance occurs. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids, including a mobility scooter parking/charging bay. The external area is well maintained. The dementia gardens have been designed with the support of an international dementia unit design specialist and are secure. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| 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 is adequate numbers of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Some bedrooms have their own ensuites and others share communal facilities. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents’ rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids including those required by hospital level care residents in the dual-purpose and hospital level rooms. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The communal areas include the main lounge in each area and several smaller lounges and separate dining areas in each of the rest home, hospital and dementia units. The communal areas are easily and safely accessible for residents. The dementia unit has several smaller seating areas and a sensory room to support residents. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The facility is cleaned by dedicated cleaning staff that are overseen by the household services manager. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.  All linen is laundered off-site and personal washing is done in the on-site laundry by dedicated laundry staff. Residents and relatives interviewed were satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and mandatory education and training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.  A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water and blankets. A gas barbeque is available.  A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Call bells are checked regularly by the domestic staff.  There is a minimum of one staff available 24 hours a day, seven days a week with a current first aid/CPR certificate. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open, allowing plenty of natural sunlight. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Maryann Rest Home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The senior registered nurse is the designated infection control nurse with support from the registered nurses and the management committee. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. |
| 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 | The senior registered nurse is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the quality management team and care staff) have good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by an external contractor and have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An electronic individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually, and provided to staff at facility meetings. Outcomes and actions are discussed at facility meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical team and nurse managers. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. Five residents (hospital level) were using bedrails as a restraint. No enablers were in use. An assessment process is in place for the use of an enabler if needed. Staff interviews confirmed their understanding about the differences between a restraint and an enabler.  Staff receive regular training around restraint minimisation that begins during their induction to the service. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint coordinator is the clinical coordinator/RN. Restraint minimisation policies and procedures describe approved restraints. A restraint approval group meets every three - four months. The agenda includes discussing residents who are using restraint, resources and equipment, review of restraint policies, audits, and training/education.  Restraint minimisation is covered in the caregiver and RN meetings (link 1.2.3.6). |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | PA Low | The restraint coordinator is responsible for assessing a resident’s need for restraint. Restraint assessments are based on information in the resident’s care plan, discussions with the resident and family and observations by staff. Assessment tools are in place for restraint use. Three hospital level residents’ files where restraint was being used were selected for review. Each file included a restraint assessment and signed consent. The restraint assessment failed to address risks associated with restraint use and therefore this information was not available in the residents’ care plans. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A restraint register is being implemented. The register identifies the residents that are using a restraint, and the type of restraint used. Five hospital level residents were listed on the register. The type of restraints used was bedrails.  The restraint assessments reviewed identified that restraint is being used only as a last resort. The restraint assessment process includes determining the frequency of monitoring while restraint is in use (link 2.2.2.1). RNs have been updated on restraint procedures and documentation requirements and take responsibility at each shift to ensure restraint monitoring is correctly documented.  Monitoring forms for the files reviewed were completed and included when the restraint was put on and when it was taken off. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | PA Low | Restraint evaluations are scheduled six-monthly in conjunction with the care plan review. The restraint coordinator reported that restraint use is also discussed in the restraint approval group meetings that take place every four months. This was confirmed in the meeting minutes. The restraint evaluation process was evidenced only by the GP’s signature. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint minimisation programme is discussed and reviewed at the approval group meetings. The reviews include identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.7  Advance directives that are made available to service providers are acted on where valid. | PA Low | All resident files sampled contained an advance directive. In three of the seven files the form was completed by the resident and the general practitioner (GP) had co-signed and confirmed that the resident was competent to have completed this. Four of seven files sampled (two from the dementia unit and two from the hospital) contained an advance directive that was not valid. | Four of seven files sampled (two from the dementia unit and two from the hospital) contained an advance directive that was not valid. One advance directive was signed by an EPOA where the resident was not deemed competent to sign. Three forms had been signed by the GP that the resident was not competent to make an advance directive, and documented as not for resuscitation, but there was no indication that this was a clinically indicated decision. The template was addressed on the day. | Ensure that all advance directives are valid.  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 | A quality programme is established. Data is collected and collated by the clinical coordinator/RN (eg, falls, infections, skin tears, medication errors, bruises). Data is also trended and analysed and is communicated to staff via the staff meetings but there were only five RN and four caregiver meetings in 2016. There were no results posted in the staff room. An internal audit programme is established but was not fully implemented in 2016. | The internal audit programme was not completed as per the internal audit schedule for 2016 (10 of 19 audits were sighted as completed for 2016). Interviews with the managers confirmed that internal audits were behind schedule in 2016. Also missing was the timely communication of quality results to staff. | Ensure internal audits are completed as per the internal audit schedule.  Ensure that staff receive timely information relating to internal audit results, trends in data and corrective actions.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Corrective actions are documented where improvements are required. Missing was evidence of the corrective actions being implemented. | There was a lack of evidence to verify that a sample of corrective actions were implemented. | Ensure there is documented evidence to confirm that corrective actions are implemented.  90 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 | An education and training programme is in place for staff that includes mandatory training and specialised training. Internal and external speakers (eg, HDC Advocacy Services, DHB, Aged Concern) are invited to present topics to staff.  Caregiver staff, activities staff and registered nurses working in the dementia unit have completed training in dementia care. Eleven caregivers work in the dementia unit with three casual staff. Five of eleven caregivers have completed an NZQA approved (ACE) dementia course. The registered nurses and two caregivers completed an online training course (‘Understanding Dementia’) through the University of Tasmania. This course is not accredited through NZQA and therefore does not meet requirements of the DHB contract for caregivers working in a dementia unit. Five caregivers have been employed for less than one year and are enrolled in an NZQA approved course. | One caregiver has worked in the dementia unit for over one year and has not completed an NZQA approved dementia course | Ensure all caregivers complete an NZQA approved course on dementia care within their first year of employment in the dementia unit as per ARC contract.  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 Low | All needs are included in the electronic care plan and these are populated in the electronic assessments. For all resident files, all identified needs except behaviour management had comprehensive and individualised interventions documented to guide staff. Behaviour management issues were assessed using behaviour assessments and behaviour monitoring charts and staff were able to describe and were witnessed to provide appropriate behaviour management techniques for individual residents, despite these not being documented in the care plan.  Wound documentation including comprehensive assessments and frequently updated wound management is completed on the electronic database. The database went live in May 2016 and staff continue to learn the programme. Not all wounds had documented reviews in the required timeframe. Discussion with the clinical coordinator and registered nurses identified that this was due to staff not being aware of the need to actively change the date in the section where the updates are documented, an issue that had been previously identified but not yet rectified.  As both issues are documentation issues relating to the implementation of the new database, the risk is assessed as low. | (i) Two care plans for residents with identified behaviours did not have interventions to manage the behaviours clearly documented.  (ii) Three of nine wounds had periods of three to four days where wound reviews had not been documented in the electronic database. | (i) Ensure interventions to manage behaviours that challenge are documented in the electronic database.  (ii) Ensure that all wound reviews are documented and saved.  60 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 | A restraint assessment is completed prior to restraint being used. The assessment process identified the need for restraint. Missing in all three restraint files reviewed was evidence of any risks associated with the restraint (cot sides). This area for improvement had been identified during a restraint audit (November 2016) but there was no evidence to support implementation (link to finding 1.2.3.8). | The assessment process failed to identify the risks associated with restraint use and therefore did not link identified risks to the residents’ care plans | Ensure the restraint assessment process identifies risks associated with the use of restraint and interventions to manage these risks are identified in the care plan.  90 days |
| Criterion 2.2.4.1  Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers. | PA Low | The evaluation of restraint is scheduled to take place six-monthly, while the resident’s care plan is reviewed. A comprehensive evaluation of restraint use for each resident had occurred prior to the implementation of the electronic clinical record system. But since its implementation, the evaluation process has included a GP’s signature only. | The restraint evaluation process was evidenced only by the GP’s signature. | Ensure the evaluation of restraint includes addressing all aspects of the criterion.  90 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

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End of the report.