

Metlifecare Limited - The Orchards

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:	The Orchards
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 August 2017 End date: 8 August 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:	33

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 Limited - The Orchards provides rest home and hospital level care for up to 36 residents. The service is operated by Metlifecare Limited and managed by a nurse manager. There is also a village at the same site which is not included in this audit. The village manager oversees non-clinical areas and the nurse manager, supported by a senior registered nurse oversee all clinical service areas. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, senior management from Metlifecare and a general practitioner.

This audit has resulted in a continuous improvement in food services. There are no areas requiring improvement as a result of this audit. Since the previous audit, improvements have been made to communication, quality and risk management, adverse event reporting, staff education, service provision timeframes, continuity of service delivery, assessment processes, care planning, activities, evaluation of care and restraint management. All areas identified for improvement at the previous audit have been addressed and are now fully embedded into everyday practice.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and family/whānau is promoted and was confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained with complaints resolved promptly and effectively.

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.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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.		Standards applicable to this service fully attained.
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The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files sampled demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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.

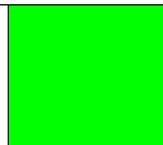


Standards applicable to this service fully attained.

There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

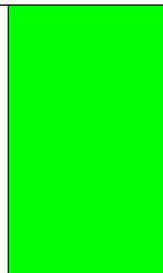


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler was in use at the time of audit. There were no restraints being used. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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



Standards applicable to this service fully attained.

Aged care specific infection surveillance is undertaken, and results 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	20	0	0	0	0	0
Criteria	1	44	0	0	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](#).

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>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that three complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow-up and improvements have been made where possible. All complaints are entered electronically into the register and oversight occurs at organisational level.</p> <p>The nurse manager is responsible for complaints management and follow-up at a facility level. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There has been one complaint received from external sources since the previous audit.</p> <p>One complaint received from the Health and Disability Commissioner which was open at the previous audit was closed in November 2016. All three follow-up actions were fully documented as corrective actions and signed off as completed. They related to communication with families, care planning and indwelling catheter management.</p> <p>In October 2016, an anonymous complaint was sent to the Health and Disability Commissioner, the Waitemata District Health Board, the Chief Executive Officer of Metlifecare and the Nursing Council of New Zealand related to some staff issues. This has been fully investigated and was closed on the 25 November 2016 with no follow-up actions required. Related documentation was sighted.</p>

		There were no open complaints at the time of this audit.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The previous audit identified areas for improvement related to the implementation and follow-up of care interventions; this has now been addressed. The caregivers and nursing staff reported there have been improvements in the communication between the staff and what is recorded in the care plans.</p> <p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the resident directed philosophy to service provision and the falls prevention programme.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Staff and family/whānau reported they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This has addressed the previous area requiring improvement. This was also evident in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff demonstrated knowledge of how to access interpreter services, although reported this was rarely required due to all residents being able to communicate effectively in English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to</p>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. A sample of monthly reports which go to the senior clinical committee and then the clinical nurse director who reports to the board of directors, showed adequate information to monitor performance is reported including financial performance, emerging risks and issues, quality data outcomes and complaints.</p> <p>The service is managed by a nurse manager who is a registered nurse with a current practising certificate. They hold relevant qualifications with over 20 years' experience in the aged care sector and have been in the role for two</p>

<p>the needs of consumers.</p>		<p>years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing education such as attendance at clinical symposiums, leadership courses and one on one coaching. The nurse manager is supported by the village manager and a senior registered nurse.</p> <p>The service holds an Age Related Residential care contract with the Waitemata District Health Board and all 33 residents present on the day of audit were receiving services under this contract at the time of audit. There were four rest home and 29 hospital level care residents at the time 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 organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, health and safety, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, wound care and pressure injury management, food services, maintenance, resident transfers, laundry and cleaning, staff education and policy and procedure updates.</p> <p>There were four areas identified for improvement in this standard at the previous audit and The Orchards could clearly demonstrate the implementation of all quality and risk management systems are now firmly embedded into everyday practice. Reporting and recording of data is detailed and easily auditable. No inaccuracy of reported or recorded incidents/data were found and this standard is now fully met by the service.</p> <p>Meeting minutes reviewed were very detailed, and along with quality data outcomes, they confirmed regular review and analysis of quality indicators and that related information is reported and discussed at senior staff team meetings, organisational clinical review meetings and all staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and awareness and involvement in corrective actions and facility based quality improvement projects. The results of the satisfaction survey have been discussed at staff meetings and the staff are asked to contribute to possible solutions for improving services. (This was documented in meeting minutes sighted).</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey (2017) showed that the service gained a 91% overall satisfaction rating. Issues that gained a lower rating in the survey are being followed up using continuous quality improvement processes. Examples sighted included family involvement in the process for making a complaint which gained a 68% satisfaction result and how complaints are dealt with gained a 76% rating. The follow up to be taken includes the development of a wall chart showing the complaints process and how complaints are dealt with. The chart is to be placed in each resident's bedroom for all family and visitors to see. Food services were also identified as an area for opportunity for improvement. A new dietary programme and processes have been implemented by the service resulting in a continuous improvement. (Refer comments in criteria 1.3.13.)</p> <p>Policies and procedures are maintained at organisational level and all policies and procedures sighted were up to</p>

		<p>date and reflected current good practice.</p> <p>There is a health and safety committee in place with a representative from each service discipline. It is chaired by the village manager. Hazards and risks are identified and managed by the committee. All risks, hazards and near miss incidents are entered into an electronic risk management event system and Metlifecare head office have oversight of all issues that arise. The Metlifecare organisation have completed a health and safety audit (AS/NZS 4801: 2001) and gained a three-year compliance (23 February 2017 to 23 February 2020). This standard sets auditable criteria for all of Metlifecare facilities' occupational health and safety management system, such as the registration and management of all contractors, identification of each area's hazards and overall risk management.</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>	FA	<p>The area related to the reporting and recording of incidents and accidents which was identified for improvement in the previous audit has been fully addressed by the service. Corrective actions implemented include additional staff education related to reporting of incidents and accidents, more frequent internal audits of resident files and incident forms using a newly developed robust audit tool. The nurse manager undertakes regular reviews of clinical notes.</p> <p>Staff confirmed they document all adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Examples sighted in all files reviewed and short-term care plans were in place for wounds and infections with regular evaluations and outcomes clearly shown.</p> <p>Adverse event data is collated, analysed and reported to the nurse manager and they are recorded electronically and monitored by head office by the clinical quality and risk manager. All incidents are reported at staff meetings and at the monthly health and safety meeting. Non-clinical risks are managed by the health and safety committee as sighted in meeting minutes and spread sheet documentation.</p> <p>The nurse manager, clinical quality and risk manager and senior registered nurse described essential notification reporting requirements, including for pressure injuries. They advised there had been one Section 31 notification of a significant event made to the Ministry of Health (November 2016), since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. This included required education for all staff, such as kitchen staff training being monitored and updated as necessary. This was an area identified for improvement in the previous audit and has been fully addressed by the service. All kitchen staff now hold current food safety qualifications.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are sufficient trained and competent registered nurses (3) who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this along with the resident satisfaction survey results which gained a 96% rating for care services. Observations and review of four weeks' rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Currently there is a high percentage of bureau use for some shifts. The nurse manager confirmed the facility is actively recruiting and this process was delayed owing to a recent infection outbreak. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage.</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. 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. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided for the monthly delivery of medication and the six-monthly stock account of the controlled drugs.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock check for all but one of the controlled drugs; one of the controlled drugs of a resident's individual prescribed medicines did not evidence a check for the week of 31 July 2017 (this is not reflective of a systemic issue). All other controlled drugs recorded the weekly check for that date, and all other weeks sampled.</p>

		<p>The records of temperatures for the medicine fridge and the medication room sampled were within the recommended range. There are no vaccines stored onsite.</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 being met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders were used, were current and complied with guidelines.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner, if a resident was assessed as competent to self-administer their medicines.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided by the co-located retirement village and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. The aged care facility recently implemented changes to the meal service to reflect the service's resident directed approach to service delivery (refer to 1.3.13.2).</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services 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. There has been no unintentional weight loss recorded in the past seven months.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements,</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools such as (pain scale, falls risk, skin integrity, nutritional screening and depression scale), to identify any deficits and to inform care planning (this addresses the previous area for improvement). The sample of care plans sampled had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of three RNs that are interRAI</p>

and preferences are gathered and recorded in a timely manner.		competent. Residents and family/whānau confirmed their involvement in the assessment process.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. All the files sampled evidenced appropriate pain management, post-operative follow-up, post falls management, wound care, challenging behaviour and pressure injury management (this addresses the previous area for improvement at 1.3.6.1). The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate to the resident's needs. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the 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	The activities programme is provided by an activities coordinator that is currently undertaking their diversional therapy training. There are planned activities five days a week. The activities attendance sheets, outing summaries and activities calendar all record the diversity in the activities programme (this addresses the previous area for improvement). 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 as part of the formal six-monthly care plan review. Individual, group activities and regular events are offered. Residents and family/whānau are involved in evaluating and improving the programme through monthly residents' meetings. Residents interviewed confirmed they find the programme enjoyable.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for management of wounds, skin care/pressure injury, pain management and preventing weight loss (this addresses the previous area for improvement). When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and family/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.

<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>	FA	<p>A current building warrant of fitness expires on 22 March 2018. There have been no changes to the facility footprint since the previous audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The infection control coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The infection control quality data includes all known infections (this addresses the previous area for improvement).</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year and comparisons against previous years and this is reported to the facility manager and wider Metlifecare quality/management team. Data is benchmarked externally within the group and other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>A summary report for a suspected outbreak in March 2017 (three residents with loose bowel motions) was reviewed and demonstrated a thorough process for investigation and follow-up. Transmission based precautions were implemented. The report of the suspected outbreak records that no infectious pathogens were reflected in the samples sent for diagnosis.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, no residents were using restraints and one resident was using an enabler, which was the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. The consent form was signed and filed in the resident file, six monthly reviews were evident and it was</p>

<p>minimised.</p>		<p>clearly shown on the resident's care plan that an enabler was in use.</p> <p>The facility has had no recorded restraint since the previous audit. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>This was an area identified for improvement in the previous audit which has been fully addressed by the service. The enabler in use is clearly shown in the restraint register sighted and regular six monthly assessments were evident. There were no restraints in use at the time of audit. Staff competencies and ongoing education ensure staff have an in-depth knowledge of the assessment process. The restraint coordinator (RN) was able to verbalise the correct use of assessment and approval processes should restraint be required.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>This was an area identified for improvement in the previous audit which has been fully addressed by the service. The restraint register sighted showed that no restraint and three enablers have been used since the previous audit. Two of the three enablers have been discontinued and the facility remains restraint free. The restraint coordinator described how alternatives to restraints are discussed with staff and family members such as the use of sensor mats, low beds and landing mats.</p> <p>Policy and education provided describes the required frequency of monitoring to ensure the resident remains safe. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at all staff meetings and by the restraint approval group at least six- monthly. The register was reviewed and contained sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in 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.

No data to display

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 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	CI	<p>The service has conducted quality improvement projects into the presentation of the textured modified food and the plating presentation of other foods, increasing variety of the foods and fluids. The residents and family/whānau have been involved in the review and suggestions for the meals. The project included the analyses and reporting of satisfaction surveys and feedback related to the food. The outcomes included residents’ increasing satisfaction with the variety of food, more choices being available, the residents being able to choose their meal options each day, and improvements to the presentation and plating of normal and special diets (including textured modified foods). The analysis for the improved health outcomes data for December 2016 recorded that there has been no unintentional weight loss since the project began. The project is now into phase two, with resident directed care being implemented into the breakfast options. The resident and family/whānau interviewed report high satisfaction with</p>	<p>The achievement of the quality projects related to the presentation of texture modified food and resident directed approaches to providing the variety of foods and fluids is rated beyond the expected full attainment. The quality improvement projects sighted have a documented review process which included analysis and reporting of findings to management, staff, residents and family/whanau. The projects documentation evidenced action taken based on findings and improvement to the presentation and nutritional value of the texture modified foods. Resident safety and satisfaction has been measured as part of the review process, which evidenced increasing resident satisfaction and reducing unintended weight loss. The residents and family/whanau interviewed reported that the meals are of a ‘restaurant quality’ and that the presentation of the textured modified food is</p>

		presentation and taste of the meals.	appetising.
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End of the report.