# Mission Residential Care Limited

## Introduction

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

The audit has been conducted by 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:** Mission Residential Care Limited

**Premises audited:** Kemp Home and Hospital

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

**Dates of audit:** Start date: 5 November 2014 End date: 5 November 2014

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 73

# 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

Kemp Home and Hospital is part of the Wellington City Mission. The service provides rest home and hospital level care for up to 81 residents. On the day of audit there were 25 rest home residents and 48 hospital level residents. The service is led by the general manager and the nurse manager. The management team are both experienced aged care registered nurses.

Kemp Home and Hospital has an organisational quality management plan that is supported by the board and the management staff.

The service has addressed four of the five previous shortfalls around consents, care planning, medication and enabler monitoring. Further improvement continues to be required around staff meeting documentation. This audit identified improvement required around aspects of care planning and aspects of medication documentation.

## Consumer rights

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

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion are available in the reception area. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

## Organisational management

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

The service has an established quality and risk management system that supports the provision of clinical care. A monthly quality meeting includes a monthly review of services and measurement against stated goals. There are monthly reports to the board by the General Manager, who attends board meetings.

Key components of the quality management system including management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections through the surveillance programme, review of risk and monitoring of health and safety including hazards and maintenance.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times. There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

## Continuum of service delivery

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

The residents` needs, outcomes and/or goals have been identified in the assessments and care plans are reviewed six monthly or more often as required. A team approach to care delivery and continuity of service delivery is encouraged. Medication management is safely implemented with one improvement required.

Food services are managed effectively. Meals are prepared on site. Nutritional guidelines and advice is available which is appropriate for this service setting. The individual dietary needs are identified during the assessment process for each resident and choices are provided. An activities programme is provided and enjoyed by the residents. Participation is encouraged but is voluntary. Activities are planned that are meaningful and the programme is developed and implemented to ensure the interests of residents are included. Community outings are arranged and entertainers are invited to participate in the programme. Special consideration is given to younger people when planning the activities programme.

## 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 which expires 5 October 2015

## 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. |  | Standards applicable to this service fully attained. |

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and an enablers register. There are three residents using restraints and nine residents with identified enablers. All enabler use is voluntary.

## 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. |

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service has appropriately managed one outbreak of scabies and two outbreaks of gastroenteritis during 2014.

## 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 | 14 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 2 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent is obtained on admission for release of health information, photograph, medical/surgical procedures, and choices of activities of daily living, information to next of kin, transport/outings and treatment services at the facility. Advance directives are appropriately signed. Discussion regarding informed consent takes place with the resident (if appropriate), significant others, the RN and GP. The consent forms are reviewed annually. Informed choice for residents is practiced as confirmed by residents/relatives interview and RN, Caregiver interviews. There is a form for withdrawal of a specific treatment should the resident choose to do so. Copies of the enduring power of attorney are available in some files. There was a previous audit finding around gaining consent for specific procedures. This audit finding has now been addressed.  D13.1: There were six admission agreements sighted and all had been signed.  D3.1.d Discussion with family identified that the service actively involves them in decisions that affect their relative’s lives. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Kemp Home and Hospital has a complaints policy, associated forms and a complaints flow chart. There is a complaints register with two verbal and four written complaints logged in 2013. There are three written, one verbal and one complaint resulting from an incident report in 2014. All complaints for 2013 and 2014 are appropriately documented with follow up in a timely manner through to resolution. There is evidence of improvements to the service as a result of complaints and these are discussed with staff at handovers and meetings. The service appropriately responded to a health and disability and CCDHB complaint in March 2013 which was resolved in October 2013 with no further follow up required. The service has made improvements to restraint monitoring and staff education following the complaint.  Complaint forms are available at the entrance to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family.  All seven residents and six family members interviewed confirm they are aware of the complaints process and they would make a complaint to the manager of other staff if necessary. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Kemp Home and Hospital information booklet is provided to residents on entry and this comprehensively includes information around rights, complaints, restraint, open disclosure abuse and neglect etc.  D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  D16.4b: All seven relatives interviewed state that they are always informed when their family member’s health status changes and the 10 incident forms reviewed for September 2014 indicate that family are informed.  D11.3 The information pack is available in large print and advised that this can be read to residents. The service has policies and procedures available for access to interpreter services noting that there are no residents requiring interpreting services.  There is an open disclosure policy, a complaints policy and an incident and accident policy and staff have had training around the code of rights including advocacy and open disclosure in May 2014.  Residents and family members interviewed state they were welcomed on entry and were given time and explanation about services and procedures.  Resident meetings occur three monthly and family are invited to this (August 2014). The manager has an open-door approach. The service has newsletters two-three monthly (September 2014 sighted) which includes relevant information on health and safety, falls prevention, IPC, and general service news  Family members interviewed said they are very happy with the communication and support they received as family members by the service. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Kemp Home and Hospital is part of the Wellington City Mission which has a CEO and board of trustees. Kemp Home and Hospital provides up to 81 rest home and hospital level care. On the day of the audit there were 25 rest home and 48 hospital residents. The service has five dual purpose beds. The service is led by the general manager and the nurse manager. Both are RNs and very experienced in their roles and have been at the service for 11 years. The general manager reports to the CEO who reports to the board of trustees.  The service has a current business and risk plan (2013-2018) that is reviewed annually though the board. Last reviewed March 2014. The plans, aims and ambitions include but not limited to; to improve the physical environment, to maintain quality systems and policies and procedures, to have fully trained staff to replace equipment, to implement InterRAI, to increase the number of trained staff and to continue to improve and review the recreational programme.  The mission statement for the service aims to provide a quality, homely environment in which frail elderly my live in an atmosphere of respect friendliness and have their physical and psychological needs met regardless of culture race or creed.  The formal review of the quality system in March 2014 included, IC, restraint, incidents and accidents, training and hazards. Monthly quality meeting provide a monthly review of services and measurement against stated goals. There are monthly reports to the board by the GM who attends board meetings. The CEO visits weekly and one of the Board Trustees volunteers for the service. The Board of Trustees meeting is held on site at Kemp Home and Hospital at least annually.  ARC,D17.3di (rest home): The nurse manager and the general manager have maintained professional development activities related to managing a rest home/ hospital. |
| 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 | Kemp Home and Hospital has a comprehensive business risk assessment and management plan (2013-2018) and this includes a quality plan. The quality and risk management plan is reviewed annually and this was last reviewed March 2014. The quality plan/goals and objectives for 2014 include plans for linking to the business plan and also specific plans including to review and further develop policies and procedures, management of risk and evaluation of services, to establish links with Tangata Whenua, to collect, collate and analyse trends of statistical information and to actively encourage input for residents, relatives and staff so that their involvement is recognised as an important part of the service deliver. The service is currently working on a major project to improve the physical environment. The service has met with the architects and hoping to have plans to start renovations within the next six months. The service is actively and openly communicating with staff, residents and families about the project and welcoming any feedback.  There is a complaints process implemented that encourages people to give feedback. Complaint forms are visible for people to access. These are reviewed by the nurse manager who also processes the suggestions.  The service has a series of meetings to communicate and monitor the quality process. These include (but not limited to); bi- monthly board meetings, once weekly meetings with the CEO, GM and nurse manager, two weekly GM and nurse manager meetings, staff meetings as required, MTD/registered nurse/clinical meetings (22 July 2014 minutes sighted), daily handover meetings, six monthly restraint meetings (16 June 2014 minutes sighted) and monthly quality meetings (30 September 2014 minutes sighted). Representatives from each service area are part of the quality committee including registered nurses, caregivers, kitchen, maintenance and domestic. The quality meeting includes reports and discussion on incidents/accidents, IC, audit and corrective actions, staff training, health and safety and hazards, restraint and enablers, medication and recreation. The service has recently contracted an external data analyst to trend falls and skin tears etc.. The first report on falls indicates the location, time of day, activity prior to the fall, risk assessment, preventative interventions and the use of restraint. The data is presented in graphs and reports that for the months January-August 2014 the largest number of falls have been in residents rooms unwitnessed. The object of the quality committee (as sighted in the meeting minutes 30 September 2014) is to meet with all staff to discuss the outcome of the report just received and corrective actions to be implemented. Meeting minutes are available in the staff room and also quality data for all staff to read.  There is an implemented audit schedule and audits are completed according to the schedule. Any audit that achieves less than 100% compliance has an action plan. Audits reviewed for 2013 and 2014 all have an action plan where needed and all action plans were documented as actioned. A residents/relatives satisfaction survey is completed annually (May 2014). The result for the survey was overall satisfaction or very satisfied.  Each month a report is completed that includes IC, incident/accidents and restraint. Reports are presented at the quality meeting for unit one (rest home and hospital) and unit two (hospital). An incident and accident report is also completed quarterly. These comprehensive reports are not documented as reported to staff through meetings. Staff interviewed (seven caregivers, five registered nurses, two enrolled nurses and one RN team leader) were aware of the reports and implications of the reports. This was a previous audit finding that still requires improvement.  There is a document control system. Documents no longer relevant to the service are removed and archived.  There are implemented health and safety policies that include hazard identification. Health and safety and hazards are discussed at the monthly quality meeting. There is a quarterly health and safety and OSH meeting which includes monitoring of hazards, and risks. A review of the documentation indicates that hazards are resolved promptly.  The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning. The services subscribes to an external provider of policies and procedures. Policies are reviewed according to a schedule and link to the Quality programme. Policies are an agenda item for staff hand over meetings. New or updated policies/procedures are available for staff in the staff room. A new policy sighted for June 2014 regarding information for residents and relatives on restraint was sighted.  Resident and relatives meetings are held three monthly (26 August 2014). This meeting is chaired by the services chaplain who visits every week. Discussion at the meetings includes quality information, health and safety, IC, staff training. Recreation and at the last meeting (August 2014) results for the May satisfaction survey were presented.  D19.2g: Falls prevention strategies are in place that include the analysis of falls incidents, sensor mats for relevant residents, increased supervision if required for a resident identified as a high falls risk and the identification of interventions on a case by case basis to minimise future 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 | The service collects incidents and accidents data. Forms are completed with details of the incident, possible cause of accident, if the family member has been contacted, evidence of corrective actions taken, if the incident is preventable and, if so, what is being done to prevent a recurrence.  Incident and accident forms are reviewed by an RN and the nurse manager.  Incidents and accidents are analysed on a monthly and quarterly basis and include (but not limited to); bruises, falls with injury, falls with no injury, skin tears and behaviour. As noted by # link 1.2.3.6, the incident and accident reviews and report are not documented as discussed at the staff meetings.  There are a total of 38 incidents for September 2014 (13 from rest home/hospital and 25 from the hospital). Ten incidents were sampled (five from rest home/ hospital and five from the hospital). The incident forms were overall fully completed, and include comprehensive RN assessment/review. Links to care plan are comprehensive and well documented, this includes monitoring plans for bruises, neuro observations where needed and management plans for falls risk and behaviour.  D19.3c The service has a standard operations procedure that describes responsibilities around reporting of a serious event. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. Public health was notified promptly of the scabies and gastroenteritis outbreaks in February, March and April 2014. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Kemp Home and Hospital employs a total of 40 staff with job descriptions in place for all positions. These include the nurse manager, registered nurses, caregivers, diversional therapist, gardener and cooks. The skills and knowledge, outcomes, accountability, responsibility, authority and functions are documented in job descriptions. Staff contracts include a code of conduct. A register of qualified nurses practising certificates is maintained (viewed). There are appropriate human resources policies in place and implemented.  Six staff files reviewed (two RN's, two caregivers, one recreation assistant and one registered nurse team leader), all had up to date performance appraisals.  An orientation programme is in place that includes the assessment of initial medication competencies if relevant for the staff member and sign off included in three staff files reviewed. Manual handling competencies is also part of the orientation. The seven caregivers interviewed could describe the orientation training including a caregiver that has recently been employed. There is a very low turnover of staff and a new staff member is always rostered on with another staff member. Orientation includes health and safety, IPC and privacy and dignity.  An annual in-service education programme is in place. The annual training plan covers a range of subjects and attendance at these is recorded on staff records. Discussions with the seven caregivers, the five registered nurses, two enrolled nurses, one RN team leader and nurse manager and a review of documentation demonstrates a commitment to the education of staff that is implemented into practice. The annual training programme well exceeds eight hours annually. Education for 2103 and 2014 was reviewed. Some topics are delivered more than once to achieve more staff attendance. At each handover a caregivers handover prompt list is completed which covers a variety of topics to ensure staff continue to learn and understand day to day activities while caring for the elderly. This includes questions on but not limited to; informed consent, incident and accident, residents rights, open disclosure, customer service, IPC, chemicals, personal cares, moving and handling, call bells, staff concerns, physiotherapy reviews, continence, hydration, nutrition, managing challenging behaviour, and effective communication. Staff discuss aspects of these topics that have occurred during their care of residents. This prompt list was introduced as a result of a complaint and staff report the effectiveness of relating and understanding/linking day to day care of the residents. There is a physiotherapist employed for at least four hour weekly and more as required.  D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, restraint and care planning |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There are two registered nurses rostered on duty in the morning and afternoon shifts. There is one registered nurse on duty on the night shift. The clinical team leader and RNs oversee the rest home. Staff turnover is low. There are currently five hospital residents in the rest home dual purpose beds an one of the registered nurses oversee these residents with assistance from the team leader (RN) and nurse manager. The nurse manager is on call and the general manager on call as required. The seven caregivers, five registered nurses, two enrolled nurses and the team leader (RN) interviewed all stated that the staffing levels were sufficient and that staffing can be increased to meet the needs of the residents. The service also has a caregiver monitor on the morning and afternoon shift who acts as a link between the caregivers and registered nurses.  All ten residents and seven family members interviewed state that there is sufficient staff on duty at all times. All relatives interviewed were complimentary about the availability of staff. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications are competency assessed annually and attend medication education. The RNs attend annual syringe driver training at the hospice. RN's interviewed were able to describe their role in regard to medicine administration and orientation of caregivers administering medications. The medico blister packs are checked on delivery and a medication reconciliation checklist is completed. Discrepancies are reported back to the pharmacy supplier. All medications are kept in a locked trolley in a locked room. The registered nurses (RN) hold the keys. The medication fridge temperature is checked weekly. All medication in the fridges, drug trolleys and on shelves were sighted. There is glucagon in stock for diabetic emergencies. All opened eye drops were dated. Currently there are no CD's in the rest home. Medication administration was observed in both the hospital and rest home areas and staff followed documented procedures, the trolleys were tidy and well set up with all eye drops dated upon opening and other medication expiry dates checked and within range. Weekly stocktakes are carried out. The medication fridges temperatures are recorded daily. There are no self-medicating residents. There is a self-medication assessment available.  The medication drug charts met all the prescribing requirements with the exception allergy documentation. Verbal order forms are used and the GPs sign the orders within 48 hours. All returns are kept in locked drug room until collected. The medication folder contains a medication administrator’s specimen signature list. There is medication information on the use of fentanyl patches, blood sugar levels and the management for hypoglycaemia and approved abbreviations. Approved biohazard containers are used for the disposal of sharps. Internal medication audits are conducted six monthly.  A previous finding in the last audit in which dittos were used as dates for the medications prescribed is now resolved, all medication charts are written in full. D16.5.e.i.2; Resident medical notes identified the GP reviews the medication drug chart at least 3 monthly and the resident is examined at least 3 monthly. |
| 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 | The service has a kitchen manual which includes; policies and procedures committed to the provision of nutritional foods; hydration needs special dietary requirements and equipment, food safety and quality review. Fridge, food and freezer temperatures (main kitchen) are monitored twice daily and documented.  The food service is a set agenda item at the residents’ meetings. There are regular annual food satisfaction surveys. Interviews with ten residents overall spoke favourable about the food. The food services policy and procedure manual is current and meets food safety and resident nutritional requirements. There is a four weekly summer and winter menu with dietitian input. The dietitian is contracted for the service with hours dependent on the need. Each resident has a dietary profile which lists type of diet, special instructions, feeding requirements, size of meal, preferences, likes and dislikes. Fluids and hydration needs are listed. The main cook confirmed there are good communication channels with the care staff and a cooks diary is used for any resident meal instructions or changes to diet. There is evidence of modified diets being provided e.g. diabetic, soft, puree and further nutritional supplements  Breakfast is served in the bedrooms with lunch and tea in the dining rooms. A bain marie is used to hold food. The food temperature is monitored daily prior to serving. The fridge and freezer temperatures are recorded daily and records were sighted. All perishable foods in the fridge are date labelled. There is a supply of sandwiches for supper and additional foods/snacks available for diabetics. Meals are covered with heat lids when delivered on trolleys to the bedrooms and hospital area. The kitchen is well equipped with a combi oven and gas stove. There are food preparation, cooking, serving, dishwashing, delivery, storage and hand washing areas. A daily cleaning schedule is in place and records sighted, planned maintenance schedule in place. Staff wear appropriate protective apparel (hats, aprons, gloves) and safe footwear. There is a trained chef who works 0530-1400, Monday to Friday and a cook who works weekends. There are three morning and two afternoon kitchen assistants daily. The chef/cook and all kitchen staff are trained in food safety, nutrition, chemical safety, infection control and health and safety. They also attend resident related in-service such as resident’s rights and elder protection.  Food services staff receive feedback from the resident meetings, verbal resident and staff feedback at the food services monthly meetings. Internal audits are conducted with feedback to the team at their meetings. Five rest home residents and five hospital residents interviewed stated they are happy with the meals and have the opportunity to discuss food at the residents meeting or any other time with management if they have concerns.  D19.2 All kitchen staff have been trained in safe food handling. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | The care plans are reviewed by the registered nurses and amended when current health changes. All five long term care resident care plans evidenced evaluations completed at least six monthly. Activity assessments and the activities care plans have been completed by the activities coordinators. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, caregivers, an enrolled nurse, and registered nurses. However the respite care resident had no care plan or interventions in place.  A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical review or sooner if determined by the GP or acute needs arise. The manager is responsible for the education programme and ensures staff have the opportunity to receive updated information and follow best practice guidelines. The seven caregivers (from the hospital and rest home), enrolled nurse, six registered nurses and the nurse manager interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including transfer belts, wheelchairs, wheel chair platform weighing scales, continence supplies, gowns, masks, aprons and gloves and dressing supplies. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Ten residents interviewed and seven interviewed were complimentary of care received at the facility.  D18.3 and 4 Dressing supplies are available. Wound assessment and wound management plans are in place for four rest home and seven hospital residents with wounds including two pressure areas. All of the wounds have been reviewed within the stated timeframe. There is evidence of GP input for four and specialist input for one resident with wounds. When a wound is healed it remains on the wound care chart for several weeks to be monitored for deterioration.  The registered nurses and nurse managers interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.  Continence management in-services and wound management in-service have been provided. During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents’ rooms and ensured residents’ dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained. |
| 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 | There is a qualified diversional therapist and three recreational officers who develop and implement a varied and interesting programme to meet the rest home and hospital resident’s physical, intellectual, cultural and social preferences. The Chaplain works closely with the team to ensure residents spiritual needs are met and visits the home weekly. The activities team meet to discuss and plan activities and the plan is developed from these meetings. A special events calendar for the year is also discussed and planned at these meetings. The plan is displayed on notice boards and every resident is given a copy in their room. There is an onsite chapel with regular church services and communions on Sunday's. Cultural needs are identified on admission and incorporated into the activity plan. There is a recreational officer on Saturdays. Residents are encouraged to maintain their links with the community. There is evidence of agency involvement including: friendship club, stroke membership, ADARDS, RSA, Age concern. The recreational officers are able to provide a full day programme of activities for the rest home and hospital wings.  The morning programme is a variety of exercise activities suited to the physical capabilities of the resident. The physiotherapist is involved in the hospital level exercise programme. An occupational therapist is available to the team for advice and support if required. One on one time is spent with hospital level residents. Activities in the programme include: Maori and pacific nations group, stories, baking, arts and crafts, housie, van trips, music appreciation, quiz and crosswords, sing a longs, indoor bowls, bocca, tai chi, visiting speakers, entertainers and visiting school groups. There are regular volunteers who enjoy assisting the team with resident activities and outings. A rest home vehicle and wheelchair taxi service is used as resident transport for drives and outings. The recreational officers attend the DT workshops and training days. They attend the clinical meetings. Three weeks after admission of a resident recreation/leisure record is completed which also includes family support/life role and history, interests past and present. The activity plans describes resident goals and plan to meet the goals. Activities progress notes are maintained and a daily attendance list for each resident. The activity care plan is reviewed at the time of the long-term care plan. Six hospital residents and one rest home resident interviewed state they enjoy the activities provided. There is a three monthly resident meeting where residents have the opportunity to provide feedback on the programme and suggestions for outings and entertainment. Activity staff have first aid training completed.  D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The RNs evaluate the initial care plans within three weeks of admission. Long term care plans are developed three weeks after admission reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted. Five of five long-term care plans evaluations are completed at least six monthly. There is a written evaluation completed by the multidisciplinary team (MDT) and includes the RN, recreational officer, physio, GP and other relevant personnel. RN's interviewed (six) state they meet weekly for clinical updates and discussion on clinical issues or resident concerns. The resident or relative is informed of the upcoming review. This was a previous audit finding that has now been addressed. Short term care plans focus on acute and short term needs and are regularly evaluated, resolved or written into the long-term care plan as an on-going problem. The RNs conduct an annual resident health care review. Relatives interviewed (five rest home and five hospital) confirmed they are notified of any care plan changes.  D16.4a Care plans are evaluated six monthly and more frequently when clinically indicated. |
| 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 warrant of fitness that expires 5 October 2015. |
| 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 | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.  Yellow individual infection report forms are completed for all infections and infections are included on a monthly register. A monthly report is completed by the infection control co-ordinator for the rest home/hospital and the hospital (unit one and unit two).  All infections are recorded and graphed monthly. This provides a trend analysis and the information is used for the annual IPC review and subsequent review of polices and training. The surveillance of infection data assists in evaluating compliance with infection control practices.  There is close liaison with the GP and the DHB IC nurse who advises and provides feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. The service has managed an outbreak of scabies in April 2014. This started 2 April 2014 and ended on 16 April. Six residents and three staff were affected. Appropriate management and communication with residents, staff and families was completed. Public health was appropriately notified. The service also had an outbreak of confirmed norovirus. The outbreak was appropriately managed and public health was appropriately notified. The service received a final report form public health detailing the norovirus outbreak and the service is currently working on implementing gastroenteritis outbreak kits. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a Restraint Minimisation and Safe Practice Policy is applicable to the service. There are also guidelines for the use of restraint and quality and risk management. Associated policies include management of challenging behaviour policy with associated forms.  The service monitors and treats all enablers as they would restraint so that all residents with an enabler have an assessment, (which includes consideration of alternatives) and a consent form. All enablers and consents are reviewed six monthly using the restraint and enabler evaluation form. This form also considers the use of alternatives. Monitoring of restraint and enablers is well documented. The previous audit finding around documentation of enabler monitoring has now been addressed.  There are documented restraint committee minutes six monthly and restraint is reviewed both on an individual level as needed and monthly through quality meetings. All staff receive training in restraint minimisation at orientation and as part of the in-service training programme. The restraint co-ordinator interviewed was able to describe clearly the minimisation strategies used. There are currently nine hospital residents requiring the use of an enabler and three hospital residents with restraint. Enablers include bed rails and lap belts, restraints include bed rails, lap belt and an anti-fiddle buckle.  The seven caregivers interviewed could describe restraint and enablers and the philosophy around their use. |

# 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 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The service collects a wide range of quality data. This includes internal audits, complaints, incidents and accidents, IC and restraint. The service completes comprehensive reports on IC and restraint monthly and incidents and accidents quarterly. These reports are reported to the board | A review of the monthly quality meetings evidence that reports are tabled at meetings however, RN and staff meetings, do not evidence that the reports are tabled at meetings. Staff reported that they are discussed, but this is not documented. | Ensure that quality data is documented as reported to and discussed by staff,  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | Eight of twelve medication charts had allergies clearly documented. | Four of twelve medication charts did not have allergies documented on the medication chart | All medication charts to have allergies clearly documented.  30 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 Moderate | Five out of six resident files evidenced a documented care plan and interventions | One rest home resident file for respite care did not have a care plan or interventions to guide care staff in care provision. | Care plan and interventions to be documented for respite care residents.  30 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.