# McKenzie Healthcare Limited

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** McKenzie Healthcare Limited

**Premises audited:** McKenzie HealthCare

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

**Dates of audit:** Start date: 26 January 2015 End date: 27 January 2015

**Proposed changes to current services (if any):** Six existing rest home beds to be assessed as suitable for dual purpose.

Six existing rest home beds to be assessed as suitable for dementia level care.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 48

# 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

McKenzie HealthCare is a stand-alone company with four shareholders and company directors situated in South Canterbury. A chief executive officer oversees the service and is managed by a nurse manager who is suitably qualified. McKenzie HealthCare provides care to up to 50 rest home and hospital level residents. On the day of the audit there were 10 rest home residents and 38 hospital residents. The activities programme provided is tailored to meet residents’ physical and cognitive abilities and includes involvement in the community. Residents and families interviewed were very complimentary of care and support provided.

This certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and general practitioner.

Improvements are required around admission agreements and consents, corrective action plans following internal audits, aspects of care planning, aspects of medication and security of residents’ files.

This audit also confirmed the suitability of an extra six beds for dual purpose and completed a partial provisional audit of six beds proposed for dementia level care. Improvements are required to ensure the environment is secure and safe, that staffing is implemented and that fire evacuation approval is completed prior to occupancy of the dementia level care wing.

## Consumer rights

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

The staff at McKenzie HealthCare ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents’ rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Residents' clinical files reviewed evidenced advanced directives. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

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

McKenzie HealthCare has a quality and risk management system in place that is implemented and monitored. An improvement is required around corrective action plans following audits. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data. Health and safety policies, systems and processes were implemented to manage risk. Incidents and accidents were reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

## Continuum of service delivery

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

Residents are assessed prior to entry to the service and a baseline assessment was completed upon admission. Residents and family members interviewed stated that they were kept involved and informed about the resident's care. Resident and family interviews confirmed their input into care planning, care evaluations and access to a typical range of life experiences and choices. Assessments are conducted for long term residents. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes and this was noted on a short term care plan. Planned activities were appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. A medicine management system is being implemented. Staff responsible for medicine management have attended in-service education on medication management and have current medication competencies. A central kitchen and on site staff provided the food service for the home. Kitchen staff have completed food safety training. Residents' individual needs are identified, documented and reviewed on a regular basis.

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

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility. All bedrooms are single and have shared ensuites or bathrooms. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. Housekeeping staff maintain a clean and tidy environment. Personal clothing is undertaken on site.  Linen is laundered off site. Improvements are required around ensuring a safe and secure environment and approved fire evacuation for the proposed dementia wing.

## 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 policy that includes comprehensive restraint procedures and aligns with the standards. There are currently no residents requiring restraint. A register is maintained with all residents with enablers. There are thirteen residents using enablers. The service has reviewed restraint as part of the quality management and staff have been trained in restraint minimisation.

## Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education has been provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate for the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## 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 | 36 | 0 | 8 | 1 | 0 | 0 |
| **Criteria** | 0 | 83 | 0 | 9 | 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 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Discussions with staff (three health care assistants, three registered nurses and the nurse manager) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Interviews with eight residents (three rest home and five hospital) and five relatives (four rest home and one hospital) confirmed the services being provided was in line with the Code of rights. Code of rights and advocacy training is provided as a regular in-service education and training topic.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | McKenzie HealthCare has policies and procedures relating to informed consent and advanced directives. A review of eight files (three rest home and five hospital) identified that seven of eight files included signed informed consent forms to allow for taking of photographs, displaying the residents name on a list at the main entrance, collecting health information and outings as part of the admission process and agreement. There is a resuscitation form and process. Resident files reviewed had completed resuscitation documentation. There were admission agreements sighted in seven of the eight files which were signed by the resident or nominated representative. Discussion with two families identified that the service actively involves them in decisions that affect their relatives’ lives. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that were available at reception. Residents’ meetings included discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identified that the service provided opportunities for the family/EPOA to be involved in decisions. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents and relatives confirmed that visiting can occur at any time. Key people involved in the resident’s life were documented in the care plans. Residents and relatives verified that they were supported and encouraged to remain involved in the community. Entertainers are invited to perform at the facility.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has a complaints policy and procedure in place and residents and their family/whanau are provided with information on admission. Complaint forms are available at the entrance of the service. Staff were aware of the complaints process and to whom they should direct complaints. A complaints folder is maintained. No complaints were received in 2013. Three written complaints were documented in 2014 and had been resolved appropriately. Systems and processes are in place to ensure that any complaint received was managed and resolved appropriately. Residents and family members advised that they were aware of the complaints procedure and how to access forms.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | The service provides information to residents that includes the code of rights, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with residents and relatives identified they were well-informed about the code of rights. The nurse manager provides an open-door policy for concerns or complaints. Resident meetings and a resident and family survey provided the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and was available at reception. The service has a resident rights and advocacy policy.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records (link 1.2.9.7), resident’s privacy and dignity. House rules and a code of conduct is signed by staff at commencement of employment. Church services are held twice monthly and resident files include cultural and spiritual values. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirmed that residents were able to choose to engage in activities and access community resources. Staff education and training on abuse and neglect had been provided.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. There are currently no residents at the service who identified as Maori. The service has established links with the Maori liaison officer for South Canterbury to review cultural policies, training and the environment. The service has links with the local Marae. Staff confirmed they were aware of the need to respond appropriately to maintain cultural safety. The service has staff that identify as Maori. Cultural awareness training had been provided. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | Care planning included consideration of spiritual, psychological and social needs. Residents interviewed indicate that they were asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they were consulted and kept informed and family involvement was encouraged.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff employment process includes the signing of house rules and a service code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries. Registered nursing staff had completed training around professional boundaries. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The quality programme monitored contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The nurse manager is responsible for coordinating the internal audit programme (# link 1.2.3.8). Policies and procedures have been reviewed two yearly. These were available in hard copy. A variety of staff meetings and residents meetings have been conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and stated that they felt supported by the new nurse manager. Care staff completed competencies relevant to their practice.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members interviewed stated they were informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur monthly (with two residents appointed as representatives) and the nurse manager has an open-door policy. Residents and family were advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken English then interpreter services are made available. All residents were English speaking on the day of the audit. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | McKenzie HealthCare is privately owned and is governed by four shareholders and company directors. The service is overseen by a chief executive officer (CEO) who is a registered nurse and has been in the role for eight years. The service is managed by a nurse manager who is a registered nurse with a considerable nursing background of over 30 years including aged care management and CEO of hospice South Canterbury. The nurse manager was appointed to the role of clinical services manager in November 2014 and then appointed as the nurse manager in December 2014 when the service restructured the management team. The service is able to provide care for up to 50 residents at hospital and rest home level care. Six existing beds were assessed at this audit as being suitable for dual purpose beds to accommodate rest home or hospital care residents. This audit also assessed six existing beds as being suitable for rest home dementia care level. There is a transition plan around the adding of dementia services. On the day of the audit, there were 48 residents in total (10 residents at rest home level and 38 residents at hospital level including one resident on a young person’s disability contract and one resident on a mental health contract). The nurse manager reports to the CEO who reports monthly to the board on a variety of management issues. There is strategic plan and quality and risk management plans in place. The nurse manager is supported by registered nurses and care staff. The nurse manager has completed more than eight hours of further education annually to support management of the service.  |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | A senior registered nurse and CEO provide cover during a temporary absence of the nurse manager.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The quality manual and the business, quality, risk and management planning procedure describe the McKenzie HealthCare quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored through the quality improvement meeting, and the various facility meetings. Monthly and annual reviews were completed for all areas of service. Meeting minutes have been maintained and staff were expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirm their involvement in the quality programme. Resident/relative meetings are held. Data is collected on complaints, accidents, incidents, infection control and restraint/enabler use. There is an internal audit schedule which is being implemented. Areas of non-compliance at audits were identified however corrective action plans were not developed to address areas of non-compliance. The service has a health and safety management system. There were implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service had comprehensive policies/ procedures to support service delivery. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Falls prevention strategies were implemented for individual residents and staff receive training to support falls prevention. Residents have been surveyed to gather feedback on the service provided and the outcomes were communicated to residents, staff and families.  |
| 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 | Incident and accident data is collected and analysed. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service notified relevant authority of a norovirus outbreak in August 2014. A sample of resident related incident reports for January 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. Reports were completed and family notified as appropriate. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Neurological observations were completed for residents with documented head injuries.  |
| 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 | The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files were reviewed and included all appropriate documentation. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Healthcare assistants undertake a compulsory training programme based on an aged care programme for the first six months and then commence modules for the aged care programme to work towards a national certificate in aged care. Annual appraisals have been conducted for all staff. A completed in-service calendar for 2014 exceeded eight hours annually. Healthcare assistants have completed either the national certificate in care of the elderly or have completed or commenced an aged care education programme. The nurse manager and registered nurses attend external training including conferences, seminars and education sessions with the local DHB. Partial Provisional:There are currently seven health care assistants that have completed the required dementia standards. These staff will be rostered into the new unit on opening. The current in-service programme includes understanding dementia, and managing behaviours that challenge. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | McKenzie HealthCare and has a weekly roster in place which provided sufficient staffing cover for the provision of care and service to residents. This includes sufficient cover for the six existing rest home beds to be suitable for dual purpose. There is at least one registered nurse and two healthcare assistants on duty at all times. The full time nurse manager is also a registered nurse. Healthcare assistants advised that sufficient staff were rostered on for each shift. Staff turnover is low. All registered nurses were trained in first aid and CPR.Currently there are eight health care assistants and two registered nurses that work on the morning shift. In the afternoon there are six health care assistants and one registered nurse. On the night shift there are two health care assistants and one registered nurse. The draft roster for the proposed dementia unit proposes that there is one health care assistant on each shift which is in addition to the current roster. There is also provision for a divisional therapist to work allocated hours in the morning and afternoon. The health care assistant in the dementia unit will be overseen by the registered nurse and the nurse manager and supported by a caregiver in the hospital/rest home as needed.Partial ProvisionalThe service has a draft roster to include rostering staff in the new dementia wing. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | The resident files were appropriate to the service type. Residents entering the service had all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Residents' files were located in the nurse’s station, however this was not a locked office and residents’ files were on open shelves. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries were legible, dated and signed by the relevant staff member. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts were in a separate folder. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment is completed on admission. The service has specific information available for residents/families/whānau at entry and it included associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission. Five family members and eight residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are signed for seven of eight resident files sampled (# link 1.1.10.4). |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form was placed on file and retained as part of the archived resident records. There was transfer information available in one of the files reviewed which was noted to be complete, appropriate, and fully documented communicated to support health care staff to meet the needs of the transferring resident. |
| 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 | All staff who administers medications have been competency assessed annually and attended medication education. All blister pack medications and other pharmaceuticals are delivered by the supplying pharmacy four weekly. The RN checks all medication on arrival and informs the supplier of any discrepancies. All medications were stored safely and all medication checks and administration meet requirements. Medication administration was observed and the staff member was compliant in the administration of medication. Specimen signing sections has been completed on every medication chart for each resident. Sixteen medication charts sampled met legislative prescribing requirements for regular medication orders. All signing sheets were correctly signed. Allergies have been documented on the resident medication charts. There was evidence of three monthly GP reviews on the medication charts. Eleven of sixteen medication charts did not have indications for use for as required medication. Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. Partial ProvisionalThe medication trolley for the dementia unit will be safely stored in a secure nurses’ station that overlooks the lounge/dining area through glass windows. All other supplied of medication will be stored in the main treatment room.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | McKenzie HealthCare provided meals to residents which were prepared and cooked onsite by an external contractor. There are two chefs employed by the external contractor to cover seven days a week. There are four weekly summer and winter menus with dietitian review and audit of menu conducted. All diets were catered for. Meals were provided in three dining rooms and transported in hotboxes and served from bain maries. There were hot food temperatures taken at each meal service and these were recorded. There were sandwiches and snacks available for residents outside of meal times. Special eating aids are provided as assessed to promote independence. Resident dietary profiles and likes and dislikes were known to food services staff and any changes were communicated to the kitchen via a dietary profile form. Staff were observed wearing appropriate protective clothing. Fridge and freezer temperature monitoring was recorded daily and records sighted. Food was stored safely. Resident meetings allow for the opportunity for resident feedback on the meals and food services generally, the supervising chef attends these meetings when invited. Interviews with residents indicate that meals were enjoyed. Staff have been trained in safe food handling. The food service is equipped to cater for an increase in dual purpose beds and dementia level care residents.Partial ProvisionalThe proposed dementia wing has an open area that will serve as the lounge and dining area for the six residents. There is a kitchenette with a fridge available and there is safe access to hot water. Meals from the main kitchen will be plated and transported to the dementia unit via hot boxes and served to resident by the health care assistant. There will be snacks available 24 hours and these will be stored in the kitchenette or in the fridge. |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The service has a process for declining entry should that occur. This included informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whanau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | An initial nursing assessment and initial care plan is completed within 24 hours of admission. Personal needs, outcomes and goals of residents were identified. There was a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) continence, b) pressure area risk assessment, c) nutrition, d) falls risk assessment, e) pain assessment, and f) behaviour assessment and monitoring (# link 1.3.6.1). The InterRAI assessment tool has been commenced and the facility is transitioning to InterRAI as new admissions are admitted and the remaining RN’s complete training. Assessments are conducted in an appropriate and private manner. All eight residents interviewed were satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, via progress notes, initial assessment and care plans. Resident and families advised that they are informed and involved in the assessment process. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | The long term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. Resident/family/whanau involvement in the care planning process was evidenced by signatures on the written acknowledgment of care plan form in the resident files sampled. Residents and relatives interviewed confirmed they were involved in their care plans. Short term care plans were in use for changes in health status (# link 1.3.8.2). Three out of eight resident files reviewed had generic typed sections in the long term care plan that did not relate to the residents identified needs.  |
| 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 | Care plans are current and interventions reflect the assessments conducted and the identified requirements of the residents in five of eight long term care plans reviewed (link 1.3.5.2). Residents interviewed reported their needs were being met. Relatives interviewed stated their relative’s needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. Faxes to the GPs for residents change in health status were sighted in the resident’s files.Dressing supplies were available and treatment rooms were adequately stocked for use. Wound assessment, wound treatment and evaluations including frequency for two chronic wounds, were linked to the long term care plans. Four of seven wounds were not managed within timeframes. Pressure area cares and interventions were documented in the long term care plans. The RNs interviewed had access to external to wound specialist as required. The GP reviews the wounds three monthly or earlier if required. Continence products were available and resident files include a three day 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 by the three RN's interviewed. Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, food and fluid charts, enablers, blood sugar levels and behaviour charts.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 | A team of activity coordinators (three) implement an activity programme for the facility. One is a qualified Diversional Therapist. All have a current first aid certificate. Activities were observed to be delivered simultaneously for the rest home and hospital residents. Resources were available for staff use at any time. Daily contact is made and one on one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. The facility has a van that can accommodate seven residents and is utilised for outings, a community van is hired twice a month and can transport two wheelchairs and other residents. This is used to visit another facility for shared activities and for outings. The resident/family/whanau as appropriate complete a life history and interest’s information sheet. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. Resident forum meetings were held monthly and open to families to attend. The activity plans were reviewed at the same time as the clinical care plans in resident files sampled. Partial Provisional:The service has developed an activity programme suitable for dementia level care residents. There is currently a diversional therapist employed by the service. Initially the diversional therapist will be allocated one hour in the morning 8.30am-9.30 am and one hour in the afternoon 3.30pm-4.30pm to work in the dementia unit. The care giver will be orientated to carry out activities for the six residents. The diversional therapist hours can be extended as required. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | All eight long term residents' files sampled evidenced that evaluations of care plans were within stated timeframes and reviewed more frequently if a resident’s condition changes. Evaluations were conducted by the registered nurse with input from the resident, family, care staff, diversional therapist and GPs. There was recorded evidence of additional input from professional, specialist or multi-disciplinary sources if this was required. Short term care plans used for short term needs were evaluated and either resolved or transferred to the long term care plan as an ongoing need, however these were not always signed off by the registered nurse when resolved. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | The service facilitates access to other medical and non-medical services. The registered nurse interviewed confirmed that residents, family and GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Relatives and residents interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available and staff were observed wearing personal protective clothing while carrying out their duties. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety data sheets were available.Partial ProvisionalThere is a secure cupboard in the proposed dementia wing where chemicals will be store securely and safely and there is access to a sluice. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building has a current building warrant of fitness that expires 1 July 2015. The maintenance person addresses daily maintenance requests. There is a 12 monthly planned maintenance schedule in place that includes the calibration of medical equipment and functional testing of electric beds and hoists (October 2014). The service has a trained electrical tester and equipment to carry out annual electrical testing (January 2015). Hot water temperatures in resident areas are monitored and stable between 43-45 degrees Celsius. Contractors are available for essential services. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. The service employs grounds and garden staff that maintain the external areas. Residents were able to access the outdoor gardens and courtyards safely. Seating and shade is provided. There is an outdoor designated smoking area. The three care assistants and three registered nurses interviewed state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. Six existing rest home rooms were viewed as suitable for dual purpose.Partial Provisional:The service has a plan to renovate an area of the facility to become a secure dementia unit with six single rooms. Renovations have not yet commenced including developing a secure outside garden area. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All bedrooms but nine have access to shared ensuites, the remaining nine rooms share three bathrooms. There were communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.Partial ProvisionalThe six single rooms in the proposed dementia unit are close to the lounge/dining area. Two rooms share an ensuite of which privacy locks and a toileting programme will be managed to maintain resident privacy and dignity. The ensuites are large enough for mobility aids to be safely used by residents.  |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | All residents rooms were single and of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites and bathrooms. Residents are encouraged to personalise their bedrooms.Partial ProvisionalAll six proposed rooms in the dementia unit are single with appropriate size to allow care to be provided and the safe use and manoeuvring of mobility aids including ensuites. Residents will be encouraged to personalise their rooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are four lounges and three dining areas. There were seating alcoves available quiet private time or visitors. The communal areas were easily and safely accessible for residents.Partial ProvisionalThe lounge/dining area is large enough for six residents and is easily accessible for residents. The lounge/dining area has access to the proposed outdoor area where there will be more seating. Residents rooms can be used for private quite times or visitors. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The facility has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits were completed as per the internal audit programme. The laundry has an entry and exit door with defined clean/dirty areas. The service has a secure area for the storage of cleaning and laundry chemicals for the laundry. There are dedicated cleaning and laundry persons on duty each day. Personal clothing is undertaken on site.  Linen is laundered off site. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing was treated with care and returned to them in a timely manner. The service is equipped to manage the additional dual purpose beds and dementia level care. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR was included in the mandatory in-service programme. There was a first aid trained staff member on every shift. McKenzie HealthCare has an approved fire evacuation plan and fire dills occur six monthly. Smoke alarms, sprinkler system and exit signs in place. The service has alternative cooking facilities (BBQ) available in the event of a power failure. There is a back-up generator and diesel fuel supplies to run this, the heating is diesel fuelled and can continue in a power outage. There are civil defence kits in the facility and stored water. Call bells are evident in resident’s rooms, lounge areas, and toilets/bathrooms. The facility is secured at night.Partial ProvisionalThe development of the six beds into a dementia wing is required to have fire safety approval.  |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows with plenty of natural sunlight. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | McKenzie HealthCare had an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control nurse with support from the nurse manager and quality team. The quality team meets to review infection control matters. Minutes were available for staff. Regular audits were conducted and education is provided for staff. The infection control programme had been reviewed annually.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There were adequate resources to implement the infection control programme at McKenzie HealthCare. The infection control (IC) nurse maintains her practice by attending infection control updates. The infection control coordinator reports to the health and safety meeting and the quality meeting. External resources and support were available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities were available throughout the facility and alcohol hand gel is all freely available.  |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies have been reviewed and updated at least two yearly.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse with support from the nurse manager. All infection control training is documented and a record of attendance is maintained. Visitors were advised of any outbreaks of infection and were advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. Education around infection prevention and control had been provided in 2014.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections were entered on to a monthly facility infection summary and staff were informed. This data is monitored and evaluated monthly and annually at facility and organisational level. A noro virus outbreak in August 2014 was appropriately managed, with notification to the relevant authority.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with clinical staff. Restraint minimisation was overseen by a restraint coordinator who is the nurse manager. There were no residents requiring restraint on the day of the audit. Twelve hospital residents and one rest home resident were using bedrails as enablers. The use of enablers is voluntary, requested by the resident. There was evidence of a full restraint assessment prior to implementing the enablers. There was evidence of the residents consenting to the enabler. In addition, there was evidence of monitoring of residents who were using enablers with three monthly review by the GP and full review of assessment and consent six monthly. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.4The service is able to demonstrate that written consent is obtained where required. | PA Low | Seven of eight resident files had evidence of signed admission agreements and written consent. | One resident who had been a resident in the facility for six months did not have a signed admission agreement or evidence of written consent. | All residents to have an admission agreement and written informed consent completed on admission.90 days |
| Criterion 1.2.3.8A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The service had an audit schedule for 2013 and 2014. There is an audit schedule for 2015 which support service delivery. All audits for 2013 and 2014 have been completed with identified areas for improvement.  | Audits completed in 2014 included (but not limited to); wounds 50%, controlled drugs 83%, and building maintenance 86% all with identified areas for improvement, however the service did not develop corrective action plans to monitor improvements required. | Ensure that corrective action plans are developed for areas of non-compliance following audits.90 days |
| Criterion 1.2.9.7Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. | PA Low | Resident’s files containing all personal and confidential information were kept on open shelves in an unlocked nurse’s station.  |  Resident’s files were not protected from unauthorised access by being locked away in the nurses’ stations. | Ensure that all resident files are protected from unauthorised access by being locked away.90 days |
| Criterion 1.3.12.6Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | Five of sixteen medication charts had indications for use of as required medications |  Eleven of sixteen medication charts did not have indications for use for as required medication documented by the GP to safely guide staff administrating medications | All medication charts to have indications for use documented by the GP for as required medications60 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Five of eight residents’ files had individualised interventions in the long term care plan to support residents care and guide staff. | Three of eight resident’s long term care plans had generic typed interventions that stated enablers (bedrails) were in use and were to be monitored two hourly, none of the three residents have used or are using enablers. | Long term care plans for each resident to be individualised and not pre populated with generic information.90 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Interventions in resident long term care plans were individualised and updated when risk assessments were reviewed in five of eight files reviewed. | (i)One resident with challenging behaviours had no triggers, interventions or frequency of behaviour assessments documented in the long term care plan. (ii) Two residents with a documented falls risk (high and super high) had no interventions documented to minimise this. The risk assessment completed did not reflect what was detailed in the care plan. (iii) Interventions in the long term care plan did not support the resident with weight loss. (iv) Two of these residents care plan interventions do not reflect the risk assessment for pressure area risk and continence assessment. (v) Four of seven wounds were not managed within set timeframes. | (i), (ii), (iii) and (iv) Ensure that all long term care plans have current, individualised interventions. (v) Ensure that wound care is managed within the documented time frame.90 days |
| Criterion 1.3.8.2Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Short term care plans were in use for unexpected events and wound management.  | Six short term care plans from 2014 that were no longer active were not signed off as resolved. | Ensure short term care plans are signed off when resolved.90 days |
| Criterion 1.4.2.4The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | There are six beds in an area of the facility that the service is planning to develop into a secure dementia wing. There is a lounge and dining area that would service the wing and all rooms are single with shared ensuites between two rooms. There is a secure nurse’s station that overlooks the dining/lounge area. The proposed dementia unit will allow freedom of movement while promoting safety of residents. The service has considered how they will manage privacy in their building plans. Windows have security stays fitted. There is a large garden area suitable to be made into a secure area. Plans were available on the day of the audit.  | The service has not commenced any building changes on the day of the audit. | Ensure the area is fitted with secure entry and exit doors. Ensure that security stays are fitted on all windows. Ensure that resident privacy and dignity is maintained during showering and toileting. Ensure the garden are is made secure.Prior to occupancy days |
| Criterion 1.4.2.6Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | The service has plans to renovate a section of the existing garden to be a secure area for residents to safely access an outdoor area. The plans include a walking track, a lawned area, raised garden beds, seating/shaded areas, a garden shed and landscaping. | The proposed secure garden area has not been completed on the audit day. | Ensure that the proposed secure garden area with features is completed.Prior to occupancy days |
| Criterion 1.4.7.3Where required by legislation there is an approved evacuation plan. | PA Low | There is an existing approved fire evacuation plan | The development of the six beds in to a secure dementia wing requires fire evacuation approval. | Ensure there is an approved fire evacuation plan. Prior to occupancy 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.