

Mitchell Court (Tauranga) 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](#).

The specifics of this audit included:

Legal entity:	Mitchell Court (Tauranga) Limited
Premises audited:	Mitchell Court
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 30 March 2015 End date: 31 March 2015
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	23

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Mitchell Court is privately owned and operated and cares for up to 35 residents requiring rest home level care. On the day of the audit there were 23 residents. The operational manager is well qualified and experienced for the role and is supported by a nurse manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

This audit has identified areas for improvement around open disclosure, advance directives, evaluation of activities plans, aspects of medication management and analysis of quality improvement data.

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.
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Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with dignity and respect. Written information regarding consumers' rights is provided to residents and families during the admission process. Residents' cultural, spiritual and individual values and beliefs are assessed on admission. A Maori health plan is incorporated into the delivery of services for Maori residents. Evidence-based practice is evident, promoting and encouraging good practice. Open disclosure following an adverse event is not always evident. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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.
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Services are planned, coordinated, and are appropriate to the needs of the residents. Quality goals are documented for the service. An operational manager and nurse manager are responsible for the day-to-day operations of the facility.

Quality and risk management processes are being maintained. Corrective actions document where opportunities for improvement are identified.

A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are being documented by staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. The education and training programme for staff is embedded into practice.

Nursing cover is provided by two registered nurses. A registered nurse is always on call when not available onsite. There are adequate numbers of staff on duty to ensure residents are safe.

The residents' files are appropriate to the service type.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Entry to the service is managed primarily by the manager or nurse manager. There is comprehensive service information available. Initial assessments are completed by a registered nurse. Care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners reviewed residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. On-going maintenance issues are addressed. Chemicals are stored safely throughout the facility. The majority of bedrooms are single occupancy and several have their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal area and dining room. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management.

Emergency systems are in place in the event of a fire or external disaster.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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No restraints or enablers are being used by the service. Staff receive education and training on restraint minimisation.

Infection prevention and control

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



Standards applicable to this service fully attained.

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 is 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 to the size and complexity of the organisation. 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	40	0	4	1	0	0
Criteria	0	88	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location in English and in Maori. Policy relating to the Code is implemented and staff can describe how the Code is implemented in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through the education and training programme. Interviews with care staff (one registered nurse and three care assistants) reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	PA Low	<p>Informed consent processes are discussed with residents and families on admission. Written consents are included in the admission agreement and additional consents are signed by the resident or their EPOA. Advanced directives are signed for separately. There is not always evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p> <p>Four of five resident files sampled have a signed admission agreement that includes consents. The other resident is on short term respite care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is included in the resident information pack that is provided to residents and their family on admission. This information is also available at reception. Advocacy contact details are listed on the complaints forms. Interviews with residents and family confirm their understanding of the availability of advocacy services. Staff receive education and training on the role of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their friends, and community groups by continuing to attend functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held two-monthly. Links to the community are in place.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register that include lodged complaints. Two complaints received in 2014 were reviewed. Both complaints were managed in a timely manner including acknowledgements, investigations, and resolutions. One complaint lodged with the Health and Disability Commissioner (HDC) in 2013 regarding a medication error remains under investigation. Responses to HDC regarding this complaint meet specified time frames.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The operational manager and/or the registered nurse (RN) discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the two-monthly resident meetings. All seven residents and three families interviewed report the residents' rights are being upheld by the service.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service ensures that the residents' right to privacy and dignity is recognised and respected at all times. The residents' personal belongings are used to decorate their rooms. Rooms are mostly single occupancy with two room's double occupancy. Two double occupancy rooms are being used for two married couples. The care assistants interviewed report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They report that they facilitate the residents' independence by encouraging them to be as active as possible.</p> <p>All of the residents and families interviewed report that their family member's privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Maori are valued and fostered within the service. Staff value and encourage active participation and input of the family/whanau in the day-to-day care of the resident. There were no Maori residents living at the facility during the audit. Cultural values and beliefs are documented in the residents' care plans.</p> <p>Staff receive education on cultural awareness during their induction to the service and as a regular education and training topic. All care assistants interviewed, including one care assistant that identifies as Maori, could describe cultural needs identified by Maori and are aware of the importance of whanau in the delivery of care.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even in a state of mental decline. Beliefs and values are discussed and incorporated into the care plan, sighted in all five residents' files reviewed. All residents and families interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any</p>	FA	<p>Professional boundaries are defined in job descriptions. In addition, staff complete a competency questionnaire relating to professional boundaries. Interviews with all care staff confirmed their understanding of professional boundaries including the boundaries of the care assistants' role and</p>

discrimination, coercion, harassment, sexual, financial, or other exploitation.		responsibilities. Professional boundaries are reconfirmed through education and training, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>Evidence-based practice is evident, promoting and encouraging good practice. Two registered nurses are employed by the service (1.6 full time equivalents). If not on site, a RN is on call seven days a week, 24 hours a day. Residents are reviewed by the general practitioner (GP) every three months at a minimum.</p> <p>The service receives support from the Bay of Plenty District Health Board which includes visits from mental health services. Physiotherapy services are available as needed. There is a monthly in-service education and training programme for staff which includes in-services, questionnaires and competency assessments. A podiatrist visits every two weeks. A hairdresser is available once a week. A van is available for regular outings. Community outings include regular visits to other aged care facilities and community activity programmes.</p> <p>All residents and family interviewed expressed their satisfaction with the care delivered. The GP interviewed is also satisfied with the level of care that is being provided.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack gives a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. Contact is maintained with family although accident/incident forms reviewed reflect family are not always kept informed.</p> <p>A family communication form is held in each resident's file. All family interviewed stated they were well informed.</p> <p>Two-monthly residents meetings provide a forum for residents to discuss issues or concerns.</p> <p>Access to interpreter services is available if needed. The information pack is available in large print and in other languages. It is read to residents who are visually impaired.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p>
Standard 1.2.1: Governance The governing body of the	FA	Mitchell Court provides rest home level care for up to 35 residents. On the day of the audit there were 23 residents living at the facility. One resident was on respite.

<p>organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>A mission statement and associated values have been developed for the service. Quality goals and objectives are established and reviewed annually. The facility is part of the Cavell Group. This group, which is comprised of five aged care facilities, share policies and procedures, provide internal auditing support for each other and provide an avenue for collegial support. The group meets six-monthly.</p> <p>The owner of the facility lives in Auckland. She has delegated operations to the operational manager and nurse manager. The owner visits the facility weekly and is provided with monthly management reports.</p> <p>The operational manager has been in the role for over four years. Previous experience includes auditing and managerial responsibilities in the health care sector. She has maintained more than eight hours of professional development activities annually related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>The nurse manager is responsible for the day-to-day operations in the absence of the operational manager. The nurse manager reports that the operations manager is always available by telephone if she has any queries.</p> <p>There are two registered nurses who are employed by the service, one being the nurse manager. They provide cover for each other when one is on leave.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>A quality and risk management plan is in place. Policies and procedures reflect evidence of regular reviews as per the schedule for document review. New and/or revised policies are discussed with staff in the monthly staff meetings.</p> <p>The quality and risk management programme includes collecting data (eg, accidents and incidents, complaints, infections). An annual internal audit schedule is in place. Data is collected, there were examples of data being analysed, trended and used for service improvements. Staff are informed regarding the number of accidents/incidents, medication errors and infections. Corrective actions are documented where opportunities for improvements are identified. Implementation of the corrective actions are not consistently documented on the corrective action forms, but were evidenced in staff meeting minutes.</p> <p>Quality initiatives developed for 2014/2015 include improving the induction programme for care assistants and addressing the high number of medication errors. Implementation of these quality initiatives is forthcoming. The operational manager reports that due to staffing issues in 2014, she was unable to implement these initiatives at the time. Corrective actions have been implemented since October 2014 due</p>

		<p>to high incidences of medication errors & UTI's. Nine service improvements were identified and implemented in relation to medications. The service identified that one of the reasons for the higher incidence of UTI's was due to incorrect methodology. This information was provided at audit.</p> <p>Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. Sensor mats are not currently being utilised by the service.</p> <p>A health and safety programme is in place which includes a hazard identification policy, hazard register and temporary hazard register. Health and safety is also included in the staff induction programme.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accident/incident reporting policy in place. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. All thirty incident/accident forms reviewed reflected appropriate follow-up actions taken by registered nursing staff.</p> <p>The service collects monthly data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information (link to finding 1.2.3.6).</p> <p>The operational manager is aware of statutory requirements for essential notification. This was also evidenced during a norovirus outbreak in December 2014 where the authorities were notified in a timely manner.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses are current. The service maintains copies of other visiting health practitioners practising certificates. Six staff files were selected for review (four care assistants and two registered nurses). Evidence of signed employment contracts, job descriptions, orientation, and training was available for sighting. Annual performance appraisals for staff are being completed. Interviews with care assistants described the orientation programme, which includes a period of supervision.</p> <p>The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance is recorded. Components of education and training also include staff completing questionnaires and visual competency assessments.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Two RNs are employed by the service, one who is the nurse manager. Each RN works 32 hours per week. An RN is available on call if not available on site. Care staff are adequately rostered to meet the</p>

appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		<p>needs of the residents. Separate laundry and cleaning staff are employed by the service with care assistants providing additional support if needed.</p> <p>Care staff interviewed reported that staffing levels and the skill mix are appropriate and safe. All residents and families interviewed advised that there is sufficient staffing on duty each shift. The roster is able to be changed in response to resident acuity.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in a secure room. Archived records are secure in separate locked and inaccessible areas.</p> <p>Residents' files demonstrate service integration. Entries are legible, dated, timed, and signed by the relevant care staff, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The nurse manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the clinical manager. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p>
Standard 1.3.12: Medicine	PA	The medication management policies and procedures comply with medication legislation and guidelines.

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>Moderate</p>	<p>Medicines are appropriately stored except two of three open eye drops which have not been dated when opened. Medication administration practice complies with the medication management policy for the medication round sighted. Medication prescribed is not always signed as administered. Registered nurses and medication competent caregivers administer medicines. All staff that administer medication are competent and have received medication management training. The facility uses a blister pack medication management system for the packaging of most tablets. The RN on duty reconciles the delivery and documents this or the medication competent caregiver if medication arrives when the registered nurses are not on duty. Medication charts are written correctly by medical practitioners and there was evidence of three monthly reviews by the GP. There is transcribing of a short term and a new resident's medication lists. Standing orders are used and comply with current guidelines. Three residents partially self-administer medicines and all have a current competency assessment.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a fully functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the chef works closely with the RNs on duty. The kitchen staff have completed food safety training. The chef and cooks follow a rotating seasonal menu which is currently in the process of review by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family/whānau members interviewed were very happy with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to residents should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support</p>	<p>FA</p>	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed and assessments were reviewed at least six monthly or when there was a change to a resident's health condition in files</p>

requirements, and preferences are gathered and recorded in a timely manner.		sampled. Care plans reviewed were developed on the basis of these assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement. Residents and their family/whanau are involved in the care planning and review process. Short term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses (RNs) (including the nurse manager) and care assistants follow the plan and report progress against the plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the wound specialist nurse). If external medical advice is required this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring and wound management plans are in place for two residents with four wounds which are being appropriately managed. The RNs have access to specialist nursing wound care management advice.
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.	PA Low	An activities coordinator is employed from 10 am to 4.30 pm, four days per week to operate the activities programme for all residents. Each resident has an individual activities assessment on admission and from this information an individual activities plan is developed by the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. All long term resident files sampled have a recent activities plan but there is no documented evidence of previous plans being evaluated. Residents and families interviewed commented positively on the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely	FA	All initial care plans are evaluated by the registered nurses within three weeks of admission. The long term care plan is evaluated at least six monthly or earlier if there is a change in health status. There is at least a three monthly review by the GP. All changes in health status are documented and followed up. Care plan reviews are signed by an RN. Short term care plans are evaluated and resolved or added to the long term care plan if the problem is on-going as sighted in resident files sampled. Where progress is different from

manner.		expected, the service responds by initiating changes to the care plan.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals were made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The building has a current building warrant of fitness. The building has a number of alcoves and lounge areas. There is a part-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities	FA	There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Several bedrooms have their own ensuites and four have shared ensuites. Toilets and

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The communal areas include the main lounge and dining area and a second lounge and dining area. In addition there are a number of smaller lounges spaced throughout the facility. The communal areas are easily and safely accessible for residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility. All laundry is done on site by care assistants. Residents and relatives interviewed were satisfied with the laundry service.
Standard 1.4.7: Essential, Emergency, And Security	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term backup power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. The operational manager reports that they aim to ensure all staff hold current CPR certificates.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents' rooms were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Mitchell Court has an established infection control (IC) programme. The infection control programme has been appropriate for the size, complexity and degree of risk associated with the service. The nurse manager is the designated infection control coordinator with support from the other registered nurses and other Cavill Group infection control coordinators. Staff meetings include review of infection control matters. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	FA	<p>There are adequate resources to implement the infection control programme at Mitchell Court. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>

infection control programme and meet the needs of the organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>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 are reviewed and updated at least two yearly.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control coordinator with support from the other registered nurse. All infection control training has been documented and a record of attendance including questionnaires has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved (there has been no recent outbreaks). Information was provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2014.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The nurse manager is the designated infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly resident infection data sheet but trend analysis is not documented (link 1.2.3.6). The diarrhoea and vomiting outbreak in December 2014 appears to have been well managed.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers including definitions. The operational manager is the restraint coordinator. During the audit there were no residents using a restraint or an enabler. Staff receive education and training around restraint minimisation and managing challenging behaviours. Staff understand the difference between an enabler and a restraint. The entrance to the facility is gated with the security code in a visible location on both sides of the gate.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	All resident files sampled have an advance directive. One of these is signed by the resident and the GP as not for resuscitation. One has been signed by the GP as resuscitation not being clinically indicated and there is evidence that there has been discussion with the family around this. The other two are for residents not competent to make an advance directive and the GP has assessed the resuscitation is not clinically indicated.	Two of the five resident files sampled contain a clinically indicated not for resuscitation order signed by the GP but there is no evidence of this being discussed with the family.	Ensure that when the GP completes a clinically indicated not for resuscitation order that there is documented evidence that this has been discussed with the family or EPOA. 90 days

<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	<p>PA Low</p>	<p>The accident/incident form includes space to document family are informed. This is also documented on the family communication sheet that is held in the front of each resident's file. A per policy, family are to be informed if there is an adverse event and associated injury. Thirty accident/incident files were reviewed for the months from November 2014 to February 2015. Accident/incident form did not always evidence family were contacted following an event. The accident incident form on these occasions (10 out of 30 reviewed) either stated 'no' or was left blank.</p>	<p>It was not always documented on the accident/incident reporting forms that family had been informed.</p>	<p>For those clients who have not specifically requested that family are not to be notified, ensure family are kept informed following an adverse event. For those clients where family are not to be informed, ensure the accident/incident form reflects this.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Low</p>	<p>Data is collected each month (eg, falls, infections, skin tears, medication errors). While data is collected and there were examples of data being analysed and evaluated. There were shortfalls around documentation to reflect this was routinely completed. The operational manager reports that staff are kept informed of the results although this is not routinely documented in the meeting minutes. A monthly summary report is completed every month for incidents accidents, and any comments completed at the bottom of the report. Monthly summaries document trending of medication errors with increases and decreases identified. Where there has been a reduction increase or no UTI's; on a number of occasions where there were documented evidence of high falls the reasoning for these and actions taken were documented. No trends in relation to times were found and therefore not documented.</p>	<p>While data is collected and there were examples of data being analysed and evaluated. There were shortfalls around documentation to reflect this was routinely completed.</p>	<p>Ensure documented evidence is available to verify that quality improvement data is analysed and evaluated with results communicated to staff.</p> <p>180 days</p>

<p>Criterion 1.3.12.1</p> <p>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.</p>	<p>PA Moderate</p>	<p>Mitchell Court has continued to review evaluate and implement new medication processes / tools to enhance safety around medication administration: This has included new medication packs, photograph and prompt sleeves for each resident in the medication file as when the photograph was on the medication sheet faxing made it difficult to decipher, separate packs for short term medications and packed controlled drugs. They have implemented spot internal reviews of progress and care records, medication signing sheets and signing of controlled drug register. All new medications are checked by the RN when they arrive or by a caregiver who is medication competent if the RN is not on duty and this is documented. Standing orders have been reviewed and a separate standing orders sheet has been signed by each doctor with residents at the facility. The RN on call must be contacted prior to standing orders medications being administered.</p>	<p>(i) The short term resident and a new resident have transcribed lists that staff are using to administer medication (this was rectified on audit day for the new resident). (ii) Two of 10 medication charts sampled had prescribed medications that have not always been signed as administered. (iii) One of three open eye drops had not been dated when they were opened.</p>	<p>(i) Ensure transcribing does not occur. (ii) Ensure administration sheets document that all medications are administered as prescribed. (iii) Ensure that all eye drops are dated when they are opened.</p> <p>60 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>All long term residents have an activities plan with individualised goals and interventions that have been developed within the last six months.</p>	<p>There is no documented evidence that previous activities plans have been evaluated and reviewed.</p>	<p>Ensure that activities plans have a documented evaluation at the time the care plan is reviewed.</p> <p>180 days</p>

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

No data to display

End of the report.