

Metlifecare Limited - Palmerston North

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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Metlifecare Limited
Premises audited:	Metlifecare Palmerston North
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 6 May 2015 End date: 7 May 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:	37

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

Palmerston North Village is a 50-50 joint venture entity between Metlifecare Limited and Palmerston North Maori Reserve Trust. There is a Board of Trustees which includes three members from each entity. Metlifecare Limited is responsible for all operational tasks. The facility is one of 23 operated by the Metlifecare Limited group and the Palmerston North facility provides rest home and hospital level care for up to 38 residents.

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

Improvements have been made to address areas previously identified for improvement with the exception of corrective action follow up relating to incident and accident review. This is included in the six areas identified for improvement at this audit. These are incident and accident reporting documentation, ensuring all resident information is not publicly accessible, consistency of care planning information, completion of evaluations to indicate the outcome, medication administration and the frequency of call bell checks.

Consumer rights

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

During the audit, residents were observed being treated in a professional manner. Staff receive regular and ongoing training on the rights of residents and how these should be implemented. Services are provided that respect the independence, personal privacy, individual needs and dignity of residents.

Policies are in place to guide staff in ensuring residents are free from discrimination or abuse/neglect. Staff are familiar with these policies and their implementation in practice. The services provided to residents are of an appropriate standard. Residents and their families reported their satisfaction with the services and the open communication with staff.

The service implements policy and procedures to ensure all complaints are documented, reviewed, followed up and fully addressed. At the time of audit there are no open complaints.

Organisational management

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

The board of trustees (the board) consists of three members from each group. The village manager reports monthly to the board on all topics related to the provision of service. Metlifecare are responsible for all operational activities.

Metlifecare Limited's governing body ensure that business and strategic planning are in place, covering all aspects of service delivery, to show how services are planned and coordinated to meet community needs. Strategic planning occurs annually. Management review and report to the Board, against set goals, quarterly.

The nurse manager, who is a registered nurse, is responsible for the care facility service delivery, with the village manager being responsible for the overall site.

The service has well established quality and risk management systems which are understood by staff. Quality management reviews include an internal audit process, complaints management, resident and family/whānau satisfaction surveys, restraint, incidents/accidents and infection control data collection. Quality and risk management activities and results are shared among staff, management and residents, as appropriate. All deficits found are managed using a well-documented corrective action process. Incident and accident forms are not always completed to meet policy requirements. This is an area identified for improvement.

Staff who work in the care unit are appropriately experienced, educated and qualified. As confirmed during resident and family/whānau interviews and in the 2014 satisfaction survey results, residents' needs are met.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

Ensuring that residents' private information is maintained in a secure manner is an area requiring improvement.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

An established care planning processes is in place to guide care delivery. Care plans are individualised, based on a comprehensive and integrated range of clinical information and include input from residents and families. The evaluation of short term care plans, the updating of care plans when resident's needs change, and ensuring consistency between identified care needs, goals and interventions are areas for improvement.

Registered nurses are on duty 24 hours each day, with either the nurse manager or the senior registered nurse available on call after hours. Residents' progress notes are updated each shift and there are well-developed processes in place, such as verbal handovers and communication sheets, to guide continuity of care.

The kitchen was well organised and maintained in a clean and hygienic manner. Staff have the appropriate food safety qualifications and all aspects of food services were well managed. The individual food preferences and dietary needs of residents are respected and accommodated. There are two separate dining areas for residents.

An experienced, fulltime diversional therapist manages the activity programme, which offers residents a variety of individual and group activities. Residents are encouraged to maintain their links with the community and a facility van is available to take residents on outings or attend activities in the community.

Medications are administered by registered nurses and senior caregivers, all of whom have been assessed as competent in relation to medicines management. Medications are prescribed in accordance with legislative and safe practice requirements. The

management of medications is safe and appropriate, with the exception of administering medications within the prescribed timeframes (vitamin injections only) which is an area for improvement.

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

There are documented emergency management response processes which are understood and implemented by the service providers. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness and the service has an approved fire evacuation plan. Medical and electrical equipment is checked at least annually by an approved provider. Residents' call bells are not being checked six monthly as required in policy and this needs to be addressed.

The facilities meet residents' needs with the provision of appropriate furnishings, single bedrooms, adequate toilet, bathing, hand washing, dining and relaxation areas.

The facility is appropriately heated and ventilated. The outdoor areas provide suitable furnishings and shade for residents' use.

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.

Restraint approval and assessment processes are in place and known to staff. Staff undertake annual education related to restraint minimisation and they have a clear understanding of the difference between enablers and restraint. Restraint is put in place for safety reasons only.

At the time of audit there were nine residents using restraints and four enablers in use. All restraints have been evaluated three monthly to ensure continued use of restraint is required. The restraint register clearly documents each restraint event and when it is next due to be evaluated. Resident and family/whānau input into approval and ongoing reviews are documented.

Internal quality reviews of the entire restraint process are undertaken every six months, the most recent being April 2015 following some quality improvements that were put in place. A 95% compliance rate was achieved. This process is very clearly documented.

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 prevention and control is well managed by the service. Staff undergo regular training related to infection control, and have easy access to an appropriate range of personal protective equipment. The infection control coordinator has received relevant training, and is supported in that role by the nurse manager and the infection control committee.

Evidence was sighted of a systematic approach to infection surveillance. The results of the surveillance programme are reported monthly, with data being benchmarked both internally and also externally with other Metlifecare facilities.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	4	2	0	0
Criteria	0	95	0	4	2	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>Education related to the Health and Disability Commissioner's Code of Health and Disability Services Consumer's Rights (the Code) is included in staff orientation, as confirmed by the nurse manager. Two-yearly education on the Code is also provided for staff, as reviewed in staff education records. When interviewed staff demonstrated a clear understanding of the Code and were able to explain how this would be incorporated into their everyday practice.</p> <p>The service regularly audits compliance with residents' rights. The last audit was undertaken in November 2014. A review of survey results revealed 98% compliance with the service's strategies to ensure resident rights are maintained.</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>	FA	<p>Residents and/or families are initially provided with information related to informed consent in the admission agreement, which must be signed as part of the admission process. This includes consent in relation to transportation, the taking of photographs, and the collection of information. Consent for additional medical/surgical treatment, such as a flu vaccination, is obtained on an as-required basis. Flu vaccinations were currently being</p>

		<p>organised for residents, and the relevant consent forms were sighted.</p> <p>Residents and families interviewed confirmed they were consistently given the opportunity to make informed choices and that their consent was obtained and respected. Family members reported they were kept informed in a timely manner about any changes to the resident's condition and were consulted in situations such as when consideration was being given to transferring the resident to a public hospital.</p> <p>The admission documentation completed by each new resident and/or their family member identified inclusions and exclusions in service. The nurse manager advised that head office maintains a database to ensure that signed admission agreements are held for every resident.</p> <p>The advance directives form includes information related to resuscitation status. All forms sighted had been completed by either the resident themselves, or their doctor if the resident was deemed not competent to make such a decision. The senior registered nurse advised these directives were reviewed three-monthly.</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 the Advocacy Service is included in the staff orientation programme and in the ongoing education programme for staff. This was confirmed in staff orientation and training records. As part of the admission process all residents are given a copy of the Nationwide Health and Disability Advocacy Service (Advocacy Service) brochure. Additional copies of this brochure were also available at reception. On interview, residents/families and staff demonstrated their understanding of the Advocacy Service, including how to contact this service.</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 unrestricted visiting hours and visitors are encouraged. All family members interviewed stated they felt very welcome when they came to visit and that they felt staff were also interested in their wellbeing.</p> <p>Outings are organised that enable residents to participate in community events while community groups and entertainers visit the facility regularly. For example, the diversional therapist reported that the facility van and a mobility taxi are used to take residents to a weekly friendship club in Palmerston North.</p> <p>If residents are well enough, they are encouraged to maintain their community interests and go on outings with their families. Residents are</p>

		also supported to access health care services outside of the facility, such as visits to hearing aid clinics or the dentist.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Complaints management is implemented to meet policy requirements. The service has a complaints register and all complaints are reported to head office. Residents can also bring up any issues or concerns during monthly residents' meetings and they are addressed using the complaints process. There are no outstanding complaints at the time of audit.</p> <p>As confirmed during management, resident and family/whānau interviews, complaints management was explained during the admission process. Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur. Complaints are a standing agenda item for both management and staff meetings as confirmed by meeting minutes sighted.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Copies of the Code and information on the Nationwide Health and Disability Advocacy Service (Advocacy Service) are provided to prospective residents and/or their family as part of the pre-admission process. The nurse manager advised that she discusses this information as part of both the pre-admission process and again at the time of admission and answers any questions they may have. Further discussions and explanations are provided as required by the individual resident and/or their family. Copies of the Code and the information on the Advocacy Service are also displayed prominently at the entrance to the service.</p> <p>All residents and family members interviewed demonstrated knowledge of resident rights and how to contact the Advocacy 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>A review of residents' records confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their lifestyle plan. Lifestyle plans also clearly identified each resident's functional abilities and included strategies to maximise the resident's independence. There was evidence that these plans had been developed in conjunction with the resident and/or their family and this was confirmed in interviews with resident/family interviews.</p> <p>All residents have a private room and are encouraged to personalise those rooms. Residents are also encouraged to use 'privacy requested' signs on their bedroom doors if they wish. During the audit visit, staff were observed</p>

		<p>to maintain residents' privacy when undertaking personal cares, to address residents by their preferred name, and to knock on closed doors before entering. Staff were also observed to interact with residents in a pleasant and professional manner. Residents and families stated on interview that they were treated respectfully and their individual needs were met.</p> <p>Staff handovers were undertaken in a manner that maintained privacy of information. All archived resident information was stored securely. Refer also to criterion 1.2.9.2 in relation to information management systems and the security of residents' clinical files.</p> <p>The service's policy related to abuse and neglect was well understood by those staff interviewed. They were able to provide examples of what would constitute abuse and neglect and the actions they would take if they suspected this. Education on this topic is part of the orientation process for new staff, and there is compulsory ongoing staff education related to abuse and neglect every two years. A review of training records revealed a good staff attendance at the most recent training session.</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>	<p>FA</p>	<p>At the time of the audit the service did not have any residents who identified as Maori but have well-developed protocols in place should they be required. The Maori Health Plan, dated January 2015, includes a range of information that would enable the service to meet the needs of any residents who do identify as Maori. This includes a copy of the Tikanga Best Practice guidelines and contact details of a range of individuals and organisations that could provide cultural support and guidance if this was required.</p> <p>Cultural beliefs and related requirements were incorporated into the resident's admission profile, which then informed the relevant section of the lifestyle care plan. This was reflected in the residents' records reviewed.</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>	<p>FA</p>	<p>Residents' personal preferences and individual requirements were included in all care plans reviewed. There was also evidence in those care plans of the resident and/or their family being involved in their development.</p> <p>All residents and family members interviewed advised they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The service has standards of conduct for staff which makes clear the actions that will be taken in relation to bullying/abuse, resident possessions, harassment and lack of respect for residents. The nurse manager advised that these standards are made available to all staff as part of the orientation process and discussed with them. There is two-yearly training related to discrimination, and training records were sighted. When interviewed, staff were able to demonstrate a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p> <p>The nurse manager also advised that a gift register is maintained and that approval of the CEO is required when staff are offered anything other than small gifts, such as boxes of chocolates.</p> <p>All residents and family members and a visiting health professional stated that residents were free from any type of discrimination or exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has a number of clinical policies to guide practice. These policies were current, relevant and referenced to relevant resources/legislation/standards. The policies reflected best practice although some of these policies were noted to be very brief. The Quality and Risk Manager advised that the Metlifecare Limited is currently finalising arrangements for a comprehensive review of all clinical policies.</p> <p>Training records sighted indicated that staff regularly attended education on clinical management issues, such as wound management and the safe management of residents with swallowing difficulties.</p> <p>On interview, two visiting health professionals expressed satisfaction with the standard of care provided to residents.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The review of residents' files demonstrated evidence of open disclosure and effective communication with residents/families and this was confirmed in interviews with family members who advised they were informed in a timely manner about any changes to the resident's status. Communication was documented in family communication sheets, on the accident/incident form and in the residents' progress notes. Resident meetings are also held approximately six-weekly and a review of meeting notes confirms residents actively participate in these meetings.</p>

		The nurse manager advised that interpreter services were able to be accessed from MidCentral District Health Board when required and information related to this was displayed on the noticeboard in the reception area.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>As required to meet policy, the Metlifecare Palmerston North Village has an up to date business plan which is in line with the direction and objectives of the organising body. Goals are documented in the operating plan and five year strategic plan. The goals and outcomes are monitored monthly by the village manager and nurse manager and reported against at board level quarterly. The business plan takes local community issues into account when the strength, weakness, opportunity and threat (SWOT) analysis is undertaken to ensure the local aged population demographics are considered and the services required for the local area are measured to identify needs. The plan shows what can be done to maximise strengths and opportunities identified and minimise weakness and threats.</p> <p>One the day of audit there were 29 hospital level care residents and eight rest home level care residents.</p> <p>The management team consists of the nurse manager and the village manager. On the day of audit the quality and risk manager was also present and represented Metlifecare at an operational level. Management have experience and qualifications, they undertake ongoing education relevant to their roles.</p> <p>Job descriptions identify management members' experience, education, authority, accountability and responsibility for the provision of services.</p> <p>Interviews with residents and family/whānau confirmed that their needs were met by the service. This is supported by 96% overall satisfaction rating from the 2014 satisfaction survey results sighted.</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>	FA	<p>The business plan outlines how the day to day operation of the service is managed and identified the reporting lines for staff to ensure the provision of services were offered to meet residents' needs.</p> <p>During a temporary absence of any member of the management team roles are covered by other members of management with assistance from the quality and risk manager and/or the operations manager from head office. This allows the day to day operation of the service to continue to meet</p>

		residents' needs.
<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>	FA	<p>Metlifecare Palmerston North Village has a quality and risk management system which is understood and implemented by service providers. This includes the development and update of policies and procedures at organisational level, regular internal audits, incident and accident reporting, health and safety reporting, restraint, infection control data collection and complaints management. If an issue or deficit is found, a corrective action is put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. Corrective actions are not signed off by the nurse manager until evaluation of the outcome occurs. Refer comments in criterion 1.2.4.3 related to outcomes not always being clearly shown on documentation.</p> <p>All policies and procedures are referenced, and the organisation has a system in place for review when policies are due. It was noted that some existing policies are brief and it was suggested that more information for staff guidance would be of benefit. The quality and risk manager confirmed that as the Metlifecare Limited service reviews policies they are checking the content to ensure accurate guidance is available for staff and this includes expanding what is contained within some policies.</p> <p>All reporting is linked to management processes via electronic media which is analysed at facility and board level. Benchmarking data is shared at all levels of service provision. At facility level this information is used to inform ongoing planning of services to ensure residents' needs are met.</p> <p>Actual and potential risks are identified and documented in the hazard register. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p> <p>Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open</p>	PA Low	<p>Policy identifies that all accidents, incidents and near misses must be recorded and reported to management accurately and within documented timeframes as identified in the flow chart procedure. For example, serious harm must be notified to management immediately and a 'near miss' must be logged electronically within 48 hours. Staff reporting of incident and</p>

manner.		<p>accidents included the family/whānau being notified to meet the principles of open disclosure.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required. Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. To complete the form outcome measures need to be shown, this is not always completed, and therefore policy is not being met. This remains as an area requiring improvement.</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>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. Staff files reviewed show that at the time of employment, referees are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff complete a comprehensive orientation programme related to the role they undertake.</p> <p>Staff undertake training and education related to their appointed roles. The education calendar is set at organisational level with additions related to the local service provision. Staff education includes regular onsite and off-site education covering a wide range of topics to ensure all aspects of service provision are met. This was confirmed in the education records sighted for 2014-2015 and during staff interviews.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted. Caregivers are required to hold an aged care qualification or be working towards one within six months of employment. The nurse manager is an aged care education (ACE) approved assessor.</p> <p>Resident and family/whānau members interviewed, along with the 2014 satisfaction survey results, identified that residents' needs are met by the service.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Organisational policy identifies that at all times, adequate numbers of suitably qualified staff are on duty to provide safe quality care. Rosters are analysed at head office to ensure staffing numbers match residents' level of care needs.</p>

		<p>A review of rosters shows that, with the exception of the diversional therapist, staff are replaced when on annual leave or sick leave. Activities are undertaken by caregivers when required. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents interviewed stated all their needs have been met in a timely manner.</p> <p>There is a registered nurse on duty at all times. The diversional therapist works Monday to Friday and there are dedicated kitchen, laundry and cleaning staff seven days a week.</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>	<p>PA Low</p>	<p>Resident-related information is kept in both hard-copy and electronic files. There are findings related to the confidentiality and security of this information. The security of the hardcopy information kept in the nurses' station was not consistently maintained during the audit visit. Resident information stored electronically is password protected, but databases remained open when a computer was unattended, and a staff member regularly accessing that computer used the log-on of another staff member to use that computer.</p> <p>Archived material related to previous residents was stored securely and systematically and was easily retrievable. Archived information for current residents was stored securely in a locked cupboard in the nurses' station.</p> <p>All components of the resident records reviewed included the resident's unique identifier. The clinical records reviewed were well-organised and integrated, including information such as medical notes, interRAI (assessment) reports, reports from other health professionals, referral information and laboratory results.</p> <p>Detailed resident progress notes were completed every shift, detailing the resident's response to service provision and progress towards identified goals. Entries made by the service providers in the progress notes included the name and designation of the person making that entry.</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>	<p>FA</p>	<p>The nurse manager outlined the processes completed as part of admission to the service. Residents must have completed an assessment by the Needs Assessment and Service Coordination Service (Supportlinks) and can only be admitted when assessed as requiring either rest home or hospital level care. The service works closely with Supportlinks and</p>

		<p>Services for the Elderly at MidCentral DHB to support residents and their families during the admission process.</p> <p>Prospective residents are provided with detailed information about the service, including the admission criteria and the processes that must be completed prior to admission and an information booklet (sighted). Information on the service is also available through the ElderNet website. Prospective residents and their family/whanau are encouraged to visit the facility prior to admission to meet with the nurse manager and complete the preadmission form.</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>	<p>FA</p>	<p>The facility uses MidCentral DHB's 'pink envelope' system to facilitate transfer of residents to and from acute care services. When a resident is transferred the senior registered nurse advised that a copy of their care plan, laboratory results, medical notes, medication chart, advance directive, most recent progress notes and a referral form go with the resident.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>Registered nurses administer the majority of medications in the facility, along with senior caregivers. All these staff have been assessed as competent in medication administration and records of competency assessments were sighted. An observation of a medication round confirmed that medications were administered in a safe and appropriate manner. All medication charts contained a current photograph of the resident. The medication was checked against the medication chart prior to verbally confirming the resident's identity before the medications were administered; the medications were observed being taken; and then the administration documented.</p> <p>Medications are supplied to the facility using a blister pack system. Evidence was sighted that these packs are checked against the medication chart by a RN on arrival to the service. Surplus and expired medication is returned to the pharmacy. All medications in the medication trolleys and stock cupboards were within current use date. The date of first use of eye drops was recorded on those products currently in use. A controlled medication count is undertaken weekly with a full stocktake undertaken six monthly, as recorded in the controlled medications register. Records of the daily check of the medication fridge temperature were sighted.</p> <p>The service is in the process of implementing the MediMap medication systems, with all but two of the medication charts reviewed being generated</p>

		<p>through that system. Medication administration is currently still being recorded in hard copy and all medication administration records sighted were complete. The service does not use medication standing orders. Processes are in place for residents to self-medicate, should this be required.</p> <p>With the exception of administering medication as prescribed, medication management complies with legislative requirements and safe practice guidelines. Four residents prescribed Vitamin B12 did not receive those medications within the prescribed timeframes, which was identified as an area for improvement.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All aspects of nutrition, safe food and fluid management comply with best practice guidelines, legislative and contractual requirements.</p> <p>Experienced and appropriately qualified staff are responsible for food services within the facility. All cooks have completed NZQA Unit Standards 167 and 168. The kitchen manager has only recently been appointed to that position, but has been on the kitchen staff in the facility for five years. On inspection, the kitchen was well maintained, clean and tidy. Food procurement, preparation, storage and disposal complied with all current legislation. Food in the fridge and freezers was dated and covered. There was evidence of stock rotation in the well-organised pantry. Cleaning and maintenance schedules were sighted. Records were sighted that fridge and freezer temperatures were monitored daily and remained within recommended ranges.</p> <p>The kitchen catered for a range of nutritional and religious requirements, including diabetic, vegetarian, gluten-free and soft diets. The 14 week menu, with summer and winter options, was last reviewed by a registered dietitian in January 2014. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs recorded on the kitchen whiteboard. Residents are weighed monthly and nutritional supplements administered as prescribed. Specialised crockery, such as lip plate and feeding cups, are available. Two dining rooms are available for residents or they may have meals in their own room if they wish.</p> <p>All residents interviewed advised they enjoyed their meals. An annual food satisfaction survey is also undertaken.</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 nurse manager advised they could not recall having to decline entry to the service, although sometimes they might not have an immediate vacancy. If a prospective resident did not meet the entry criteria, or there was currently no vacancy, then the nurse manager would work with them and Supportlinks to support them to find appropriate care/placement.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The senior registered nurse advised that residents are assessed by a registered nurse within 24 hours of admission, which was confirmed in the review of residents' records. A short term care plan is developed utilising a range of information provided by the resident/family, the support needs assessment, clinical assessments, such as falls risk and pressure area risk, together with the interRAI assessment and any other relevant referral information. Within three weeks of admission a long term care plan is developed. All residents' records reviewed demonstrated evidence of a comprehensive assessment process which also includes resident/family involvement. All assessments seen were completed in a timely manner.</p> <p>Four nursing staff have completed the interRAI assessment training, with 21 residents currently entered onto the system.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Residents have an individualised care plans. This was sighted in all of the residents' records reviewed. The service is currently in the processes of moving from a paper-based care planning system to an electronic care planning system, a hard copy of the electronically generated care plans are also kept in the resident's record.</p> <p>All long-term care plans developed using the original paper-based system reflect the support needs of residents, and the outcomes of the integrated assessment processes, including interRAI and the input of other health professionals, such as doctors, physiotherapists and speech-language therapists. The identified care needs, care goals and planned interventions were consistent with the assessment.</p> <p>The care plans developed using the electronic care planning system also reflected an integrated assessment process. However in four of those plans there were inconsistencies between the assessment and the identification of care required, the goals of care and the interventions planned to achieve these goals.</p> <p>Short term care plans reviewed did not include a treatment goal, were not</p>

		evaluated regularly and when progress was slower than expected long-term care plans related to the issue were not developed. Refer also to standard 1.3.8 evaluation.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>There was evidence in all residents' records reviewed of care services being delivered in response to assessed needs and desired outcomes. Detailed entries were sighted in the residents' progress notes especially when there were any changes to a resident's needs. Registered nurses are on duty 24 hours a day who provide support and guidance for care delivery staff. All residents and families interviewed expressed their satisfaction and comfort with the services provided. The service also has well-established links with a range of visiting health professionals and specialist services. Evidence was sighted of prompt referral to specialist services when further guidance/support was required to manage specific clinical situations.</p> <p>On interview, a doctor and another visiting health professional stated their satisfaction with the standard of care delivered by the service.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	FA	<p>A qualified diversional therapist (DT) with six years' experience in the role, is employed 40 hours weekly to coordinate the residents' activity programme. Residents' previous and current interests are assessed on admission and individual activity plans completed within three weeks and reviewed three-monthly. This was confirmed in residents' records reviewed. These plans help inform the development of the monthly activity programme.</p> <p>The activity programme is well promoted within the facility, with residents receiving individual copies of the weekly activity plan and the day's activities highlighted on a whiteboard. Activities are provided both in a group and on a one-on-one basis and include crafts, music, twice-weekly outings in the van, baking, entertainment, church services and housie. All residents and families interviewed confirmed their satisfaction with the variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Moderate	<p>The senior registered nurse advised that long-term nursing care plans were evaluated at least six monthly by a registered nurse, which was confirmed in the care plans reviewed. These evaluations detailed the resident's progress towards achieving their identified goals and reflected any changes arising from the clinical reassessments undertaken as part of the evaluation</p>

		<p>process.</p> <p>Wound care and short term care plans are evaluated irregularly. Long-term nursing care plans are not updated when progress related to short term clinical issues, such as wound care, is slower than expected. Refer also to criterion 1.3.5.2.</p>
<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	<p>The right of residents to access other health and/or disability providers is maintained. Residents are able to choose who will provide their medical services with most being able to retain the services of their own doctor. Residents who want or need to obtain a new doctor are supported in this process. The senior nurse explained the referral process when a resident requires specialist provider assistance and copies of such referrals were sighted in residents' records. A resident/family interviewed confirmed that they are kept informed about the referral processes. Support is available to transport and accompany residents to external health-related visits, as sighted in residents' records and confirmed during interviews with families.</p>
<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	<p>Policy and procedures sighted encourage the careful handling of all waste to reduce the potential for injury or illness associated with handling and transport of all waste and hazardous substances.</p> <p>All chemicals used for cleaning and laundry are safely stored and correctly labelled. Staff have access to personal protective clothing and equipment. This is confirmed during interview.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Documentation sighted identified that all processes are undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires 31 August 2015. There is a maintenance plan which is overseen and managed by the village manager. There is an established reactive maintenance process in place to ensure newly found issues can be addressed. Maintenance has been undertaken by both internal maintenance and external contractors as required.</p> <p>Electrical safety testing occurs annually. The planned maintenance register identifies that clinical equipment was tested and calibrated by an approved provider at least annually or when required.</p> <p>The physical environment minimises the risk of harm and promotes safe</p>

		<p>mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, and walking areas are not cluttered. Mobility aids are used correctly as identified by the physiotherapist/occupational therapist. Regular environmental audits sighted identify that the service actively works to maintain a safe environment for staff and residents.</p> <p>There are easily accessed, level surface, shaded outdoor areas for residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>There are adequate toilet/shower facilities for residents with separate staff and visitor facilities. All bedrooms have toilet and hand basin ensuite and shower areas are centrally located in each wing. Vacant and engaged signs were not on all doors but this was rectified at the time of audit. Hot water temperatures are monitored and documentation identified that safe water temperatures are maintained.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms are single occupancy and of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. They are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal belongings.</p> <p>Resident and family/whānau members interviewed confirmed they were happy with their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are two lounge and two dining areas. One lounge and dining area can be used as one room by opening a concertina door which divides them if a larger room is required. Areas contained comfortable furnishings to meet residents' needs. Residents and family/whānau voiced their satisfaction with the environment. Activities are undertaken in both lounge areas and there is also a dedicated arts and craft activity room for resident use. Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The service has documented procedures in place for cleaning and laundry tasks. Chemicals are securely stored and appropriately labelled. Dedicated cleaning and laundry staff maintain the documented daily cleaning schedule. The facility looks and smells very clean.</p> <p>The washing machine cycles are checked by the chemical provider. Washing machines are contracted for regular maintenance by an approved</p>

		<p>provider. This check occurred during the time of audit. Laundry staff understand what each wash cycle is for.</p> <p>During interview, residents and family/whānau confirmed they are happy with the laundry services provided and the cleanliness of the facility.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>Emergency management policies and procedures implemented guide staff actions in the event of various emergency events.</p> <p>The emergency evacuation plan and general principles of evacuation were clearly documented in the fire service approved fire evacuation plan. Fire equipment is checked annually by an approved provider. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service.</p> <p>Emergency education and training for staff includes six monthly trial evacuations. The last trial evacuation identified some minor areas for improvement and no documented follow up was sighted. This was discussed with the nurse manager who said the issues are being taken to the health and safety and staff meetings later in the month.</p> <p>Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and gas BBQs for cooking. Emergency supplies and equipment include food and water should they be required.</p> <p>Staff are required to ensure windows are securely closed at night and the exterior doors are on automatic locking mechanisms. Visitors either ring the bell for entry or use a code to open the door. An off-site security company undertakes regular night patrols. There is adequate outdoor lighting. Staff and residents interviewed confirmed they feel safe at all times.</p> <p>Call bells are located in all residents' bedrooms and policy requires that they are checked six monthly. This has not occurred and is an area identified for improvement. Resident and family/whānau interviewed confirmed call bells were answered in an acceptable timeframe.</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</p>	FA	<p>All resident areas have at least one opening window for natural ventilation and light. The facility has under-floor water central heating throughout and residents and family/whānau confirm that the environment is maintained at a suitable temperature throughout the year. Some residents also have oil</p>

comfortable temperature.		filled heaters in their rooms if they wish.
<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>Well-organised and systematic processes in place guide infection control management at the facility. Comprehensive resources are available to guide staff, with two current infection control manuals available. One of these is a manual developed by an external agency, the other a Metlifecare Limited (NZ) manual which has been operationalised for each facility. These resources include definitions, procedures, guidelines to identify infections, information for all employees related to accidents, spills, needle stick injury prevention, sharps management and single-use items. Staff are clear about the use of each manual. The senior registered nurse is the designated infection control coordinator (ICC). Infection control matters, including surveillance results, are reported monthly to the nurse manager and also to the organisational quality and risk manager and director of nursing. All infection control data is analysed at both a service and organisational level, with benchmarking reports regularly developed. The Infection Control Committee meets quarterly, or more frequently if required. Meeting minutes and monthly reports were sighted. The results of the surveillance programme and any other infection control matters are shared with staff via the regular staff meetings and at staff handover meetings. This was confirmed in staff interviews.</p> <p>A sign at the main entrance to the facility ask anyone who is or has been unwell in the past 48 hours to not enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICC has appropriate skills, knowledge, qualifications and experience for the role. A range of established networks, such as with the Infection Control Team at MidCentral DHB and the Public Health Unit, and advice from Metlifecare Limited NZ can also be accessed when additional support/information is required. The ICC advised that she attends regular education related to infection control and this was confirmed in her training records. The ICC advised that she has access to residents' records and diagnostic results to ensure timely treatment and resolution of infections.</p> <p>Staff confirmed the availability of protective equipment. This includes disposable gloves and hand sanitiser in all residents' rooms. A supply of additional equipment in case of an infection outbreak was sighted.</p>

		The Infection Control Committee comprises the infection control coordinator, the nurse manager, village supervisor, housekeeping, kitchen manager and senior caregiver, ensuring an appropriate range of skills and expertise for their role.
<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>Two comprehensive policy/procedure manuals guide infection prevention and control practices. These comply with relevant legislation and current accepted good practices. Both manuals are reviewed regularly. Staff are clear about the use of each manual.</p> <p>During the audit visit, housekeeping and kitchen staff were observed to be compliant with generalised infection control practices. Care delivery staff were observed using hand-sanitisers on a regular basis and wearing disposable aprons and gloves as appropriate.</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>Infection control is a component of the staff orientation programme. Annual infection prevention and control education has been provided to staff, as confirmed in staff training records and the annual education plan. The next training session is scheduled for July 2015.</p> <p>Education is provided by suitably qualified registered nurses, including the ICC. The ICC also advised that additional staff education is provided on an as-required basis, such as if there was an infection outbreak or if there were an increased incidence of resident infections, such as urinary tract infections.</p> <p>Education with residents is generally on a one-to-one basis. This may include reminders about hand-washing or strategies to minimise the spread of coughs and colds.</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>The service operates an organised and robust infection surveillance programme. Surveillance of an appropriate range of infections is undertaken on a monthly basis. This includes data related to soft tissue, urinary tract, respiratory, oral, eye and gastrointestinal infections. The infection control coordinator develops the monthly surveillance record, which is generated from infection data reported via the accident and incident reporting system. Evidence was sighted of the infection reports generated for individual residents and the comprehensive analysis undertaken of these by the ICC. Infection summaries for individual residents were also sighted in their clinical records. Surveillance results are reported to the nurse manager,</p>

		and to Metlifecare Limited NZ head office. Benchmarking reports, which include both internal benchmarking and trends and benchmarking with other Metlifecare facilities, were sighted. Surveillance results are also reported to the Infection Control Committee and reported at staff meetings, as recorded in meeting minutes. The ICC advised that surveillance results were also informally shared with staff at regular handover meetings.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard (NZS 8134.2008). It states that the service aims to minimise the use of restraint and to ensure that if restraint is necessary, to keep the resident safe from harm from both themselves and others and that the practice occurs in a respectful manner. This includes the use of enablers which are voluntary and the least restrictive option to meet the needs of the resident.</p> <p>The service had two more restraints in use at the time of audit than the same time in 2014. The restraint coordinator confirms that some of the bedside rails are in use at the request of family/whanau members who feel it is necessary for resident safety. Currently there are 11 restraints (nine bedside rails, one trunk belt and one chair lap belt) in use or safety reasons only. There were also four bedside rail enablers in use to keep residents' safe whilst remaining as independent as possible.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>Policy identifies the responsibility for the restraint process and approval. This was understood by all clinical staff interviewed and annual education related to restraint is a mandatory topic. Staff education includes safe restraint use and challenging behaviour management. Policy states that the cultural, clinical and safety needs of the resident must be met when dealing with challenging behaviour.</p> <p>Documentation is completed for restraint approval and identifies resident and family/whānau input as appropriate. Three residents' files were reviewed to look specifically at restraint and enabler use. All paper work was fully completed and the use of restraint is shown on the care plan. The nominated restraint coordinator (RN) leads the restraint approval process.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is</p>	FA	<p>The assessment undertaken prior to restraint being approved covers all risks and meets safe practice standards. Assessment are undertaken by a RN and discussed at the restraint committee meeting. The resident,</p>

undertaken, where indicated, in relation to use of restraint.		family/whānau and GP as involved in the assessment process.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	As per policy, alternative safety measures are trialled, such as low beds, prior to restraint being used. The only restraints being used by the service are bedside rails and two types of chair lap belts for safety reasons only. Once restraint is approved it is documented in the restraint register which establishes a record with sufficient information to provide ongoing auditing of restraint use. The restraint register sighted is very clearly written and details all aspects of current and past restraint use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint committee meeting minutes and the restraint register identify that all restraint use is evaluated at least three monthly. The review involves the resident, family/whānau, the GP, and two RNs one being the restraint coordinator. The restraint coordinator understands this process.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	As per policy, a six monthly review audit is undertaken to ensure all process meet policy requirements. The review identifies that there was one skin tear incident when a resident's bedside rail cover had slipped. Corrective actions were identified. The policy has been reviewed along with staff education. The quality review identifies that all processes have been met.

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)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>All incidents and accidents are reported and documented on a specific incident and accident form. Interviews with staff confirm they understand and implement procedure as described in policy. Information is then reported to head office electronically and signed off by the nurse manager prior to being closed off. The form identifies corrective actions that have been put in place but the areas on the form to report outcomes is not always completed. This does not meet policy requirements.</p>	<p>Incident and accident forms reviewed for 2015 identify that outcomes gained following corrective actions are not well documented. This section is always completed but often mirrors actions taken and does not measure outcome of actions taken as required.</p>	<p>Ensure all areas of incident and accident reporting is completed to the level required to meet policy.</p> <p>180 days</p>
<p>Criterion 1.2.9.7</p> <p>Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.</p>	PA Low	<p>Hard copy resident information currently in use was kept in the nurses' station, which has a keypad on the door to ensure the privacy of this information. During the audit visit this door was noted to have been left open on four occasions without a staff member being present.</p> <p>Electronic files containing resident-related</p>	<p>Resident information of a personal nature is not maintained in a secure manner.</p>	<p>Ensure residents' information is maintained in a secure manner that is not publicly accessible. Staff who use the facility's computers have their own personal log-on.</p>

		information were password protected and designed only to be accessed by designated staff. During the audit visit it was noted that the computer at reception was not logged off when unattended. A staff member who regularly accessed that computer did not have a personal computer log-on, and used the log-on of another staff member.		180 days
<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>	PA Low	All aspects of medication management comply with legislative requirements and safe practice guidelines, with the exception of the administration of Vitamin B12 injections. Seven residents are currently prescribed this medication, but in four instances the medications were not administered within the prescribed timeframes.	Medications were not administered within the prescribed time frames (Vitamin B12 only).	<p>Ensure all medications are administered as prescribed.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	<p>The identified care needs, care goals and planned interventions to meet those goals did not consistently reflect the integrated assessment in all four of the care plans developed using the electronic care planning system. For example the identified care needs were contradictory in one care plan; in two other plans goals had been developed although no care needs related to those goals were evident. Although many of the detailed interventions included in the care plans were relevant to the assessment, others included were not directly related to identified care needs and/or goals.</p> <p>In all four of the short-term wound care plans and two other short term plans reviewed, no treatment goal was sighted. The form used by</p>	<p>There are inconsistencies between assessed needs, resident goals and/or interventions in the care plans developed using the electronic care planning system .</p> <p>Short term care plans do not include treatment goals.</p> <p>Short term care plans were not always developed when clinically indicated and long term care plans are not updated to reflect unresolved short term issues.</p>	<p>Ensure care plans developed by the electronic care planning system reflect the assessment and clearly describe the required support needs, goals and/or interventions to ensure all residents' needs are met.</p> <p>Develop short term care plans where clinically indicated and Include treatment goals in short term care plans.</p> <p>Ensure long term care plans are updated to reflect unresolved short term</p>

		<p>the service for short-term care planning does not include a treatment goal.</p> <p>Three of the short term plans had been in place for a number of months but the long term nursing care plans for these patients did not reflect this.</p> <p>A short-term care plan was not developed in response to an acute exacerbation of a resident's chronic condition and their long term care plan was not updated to reflect the changes in needs.</p>		<p>issues.</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Moderate</p>	<p>When residents require wound care a short term care plan is developed and a wound assessment/treatment/review form is commenced. The documentation related to four residents requiring wound care was reviewed. The evaluation of progress towards wound healing was inconsistently documented in all of these plans.</p> <p>Short term care plans were not closed off and/or transferred to long term care plans when the care need was not able to be resolved. One short term plan sighted had been in place for more than twelve months, with no evaluation of the plan during that period.</p>	<p>Wound care and short term care plans are evaluated irregularly. When short term care needs were unable to be resolved these were not closed off and/or identified on the long term care plan.</p>	<p>Ensure regular evaluations are undertaken of residents' progress towards identified short-term problems. Ensure when a residents' progress towards identified short term problems takes longer than expected the information is transferred to a long term care plan.</p> <p>90 days</p>
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA Low</p>	<p>All resident areas have a call bell system in place. However policy states they will be checked six monthly with documented evidence kept of this. This has not occurred since August 2014.</p>	<p>Six monthly call bell checks are not being undertaken.</p>	<p>Ensure policy requirements are met by undertaking six monthly call bell checks.</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.