# Mission Rest Home Limited

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Mission Rest Home Limited

**Premises audited:** Mission Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 May 2016 End date: 23 May 2016

**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:** 21

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Mission Rest Home provides residential care for up to 31 residents who required rest home level care. The facility is operated by Mission Rest Home Limited, a charitable trust.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

The five areas requiring improvement from the previous audit relating to resident’s documentation and completion of corrective action plans have been addressed.

## 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. |

Staff demonstrated an understanding of residents' rights and obligations. Information regarding residents’ rights, access to interpreter services and how to lodge a complaint is available to residents and their family. Staff communicated with residents and family members following any incidents/accidents as appropriate.

The facility manager is responsible for the management of complaints. A complaints register is maintained.

## Organisational management

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

Mission Rest Home Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at Mission Rest Home and documented scope, direction, goals, values, and a mission statement were reviewed. Systems are in place for monitoring the service, including regular reporting by the facility manager to the general manager and the trust board.

The facility is managed by an experienced and suitably qualified manager. The facility manager is supported by two registered nurses who are responsible for oversight of the clinical service in the facility.

There is an internal audit programme. Risks are identified. Adverse events are documented on accident/incident forms. Corrective action plans are being developed, implemented, monitored and signed off. Quality and staff meetings are held and there is reporting of clinical indicators, quality and risk issues and discussion of any trends. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resources management and human resource processes are followed. There are current annual practising certificates for health professionals who require them. An in-service education programme is provided for staff and attendance sheets are held on file. Staff are also encouraged to complete the New Zealand Qualifications Authority Unit Standards. Review of staff records evidenced individual education records are maintained.

There is a documented rationale for determining staffing levels and the skill mix in order to provide safe service delivery that is based on best practice. The facility manager and registered nurses are rostered on call after hours. Care staff reported there are adequate staff available and that they are able to get through their work.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

Residents’ needs are assessed on admission by the multidisciplinary team. All residents’ files sighted provide evidence that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved, and that the care provided is of a high standard.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents.

The menu has been reviewed by a registered dietician as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

A current building warrant of fitness is displayed. There have been no changes to the layout of the building that has required change to the approved evacuation scheme.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The organisation has processes in place for determining safe and appropriate restraint and enabler use. The policy identifies that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. The care staff demonstrate knowledge and understanding of safe restraint management processes, including enabler use.

## 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. |

Surveillance of infections was occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed. The results of surveillance are reported through all levels of the organisation, including governance.

## 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 | 18 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The facility manager is responsible for managing complaints and there are systems in place to manage the complaints processes. A complaints register is maintained. There is evidence that complaints are managed appropriately.Complaints policies and procedures are compliant with Right 10 of the Code. There are systems are to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and displayed. Reporting of complaints to staff was evidenced in the quality and staff meeting minutes. Care staff confirmed this information is reported to them via staff meetings.There have been no investigations by the Health and Disability Commissioner (HDC), Ministry of Health, the DHB, the Accident Compensation Corporation (ACC), Police or Coroner since the previous audit. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The facility manager advised interpreters are accessed through the local DHB if required. Residents and family confirmed communication with staff was open and effective. Family are consulted and informed of any untoward event or change in care provision of their relative. The collated resident and family survey for 2015 confirmed effective communication with residents and families. Families stated they are also included in care reviews and review of resident files confirmed this. The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the education programme. Staff confirmed their understanding of open disclosure. Communication with relatives was documented in the residents’ files. Incident/accident forms evidenced families being informed when incidents occurred. Staff were observed to introduce themselves to residents upon entering the resident's room and staff are identifiable by their name badge. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Mission Rest Home Limited is the governing body and is responsible for the services provided. The current business plan includes a mission statement, vision, purpose and objectives.The facility manager reports weekly to the general manager, and three monthly to the trust board.The facility is managed by an experienced and suitably qualified manager who has been in this position for eleven weeks. The facility manager is supported by two registered nurses. The RNs are responsible for oversight of the clinical service in the facility. Support is also provided by the previous facility manager and the general manager.Mission Rest Home is certified to provide rest home level care. On the day of this audit there were 21 rest home level residents. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management plan guides the quality programme and includes goals and objectives. There was evidence that quality improvement data is being collected, collated, and comprehensively analysed to identify trends and improve service delivery. Corrective action plans are being developed, implemented and reviewed. The requirement from the previous audit has been addressed. There is an internal audit programme and completed internal audits for 2015 and 2016 were reviewed. The relative/resident satisfaction survey for 2015 indicated that residents and families are satisfied or very satisfied with the services provided. Monthly quality and staff meetings are combined and there is reporting of clinical indicators and quality and risk issues. Care staff reported that copies of meeting minutes are available for them to review in the staff areas. Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and references legislative requirements. Policies and procedures are reviewed by the general manager and are current. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery. Actual and potential risks are identified and documented in the hazard register. The hazard register identifies hazards and shows the actions put in place to minimise, isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood and implemented documented hazard identification processes.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Adverse, unplanned or untoward events are documented by staff. Data is collated and includes summaries and registers of various clinical indicators. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. There is an open disclosure policy. Residents’ files evidenced communication with families following adverse events involving the resident, or any change in the resident’s condition. Family confirmed they are advised in a timely manner following any adverse event or change in their relative’s condition.Staff stated they are made aware of their essential notification responsibilities. Through: job descriptions; policies and procedures; and professional codes of conduct. Review of staff files and other documentation confirmed this. Policy and procedures comply with essential notification reporting. Staff confirmed they are aware of reporting requirements. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are human resource management policies and procedures. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, completed orientation, competency assessments and police vetting.The facility manager is responsible for managing the in-service education programme. In-service education is provided for staff at least monthly. Individual records of education are maintained and competency assessments are current. Care staff are encouraged to complete a New Zealand Qualification Authority education programme. There is an orientation/induction programme and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided. Staff performance appraisals are current. Annual practising certificates are current for staff and contractors who require them to practice.Care staff confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education and currency of their performance appraisals. The two registered nurses have completed the InterRAI education. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes that is based on best practice. The minimum number of staff is provided during the night shift and consists of two caregivers. The facility manager and the RNs are rostered on-call after hours. Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and family reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All resident records were legible and the name and designation of staff completing the entry is identifiable. The requirement from the previous audit has been addressed. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is comprehensive and identifies all aspects of medicine management. A safe system for medicine management is observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Controlled drugs are stored in a separate locked cupboard. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records.The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range. The GP’s signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine chart. Two residents’ who self-administer their medicines have appropriate processes in place to ensure this is managed in a safe manner. Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified. Standing orders are not used. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident’s medication chart. PRN medication requests include indications for use. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietician’s documented May-2015 assessment of the planned menu. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs, is sighted. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as is verification of compliance. Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | As verified by observation, interviews and documentation, on admission, residents have their needs identified through a variety of information sources that includes the Needs Assessment and Service Coordination (NASC) agency, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident’s bedroom, with the resident and/or family/whanau present if requested. Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. A medical assessment is undertaken within 48 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable. A multidisciplinary assessment is undertaken yearly. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents’ needs and desired outcomes. Residents and family/whanau members expressed satisfaction with the care provided.There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents’ needs. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. A residents’ meeting is held every two months. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management is responsive to requests. Interviews verify feedback is sought and there is satisfaction with the activities offered. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported on the handover sheet and in the residents’ progress notes. If any change is noted it is reported to the RN. Formal care plan evaluations, following reassessment to measure the degree of a resident’s response in relation to desired outcomes and goals occur every six months or as residents’ needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan. A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident’s general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews, verified residents and family/whanau are included and informed of all changes. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed. There have been no building alterations since the previous audit. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance of infections is occurring and is the responsibility of the infection prevention and control nurse.Incidents of infections and the required management plan are presented daily at handover to ensure early interventions. Surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions. Incidents of infections are presented at the quality/staff meetings and any ongoing corrective actions discussed and implemented as evidenced by meeting records, infection control records and staff interviews.  |
| Standard 2.2.1: Restraint approval and processesServices 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.  | FA | The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. The service aims to minimise the use of restraint and to ensure that if restraint is necessary the resident is kept 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. There is one enabler and one restraint currently in use. The restraint register identifies when restraints are commenced and when they are stopped if no longer required. Staff interviews confirm their knowledge and understanding of safe restraint use. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |
| --- |
| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

|  |
| --- |
| No data to display |

End of the report.