

Maygrove Care Limited - Maygrove Village

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:	Maygrove Care Limited
Premises audited:	Maygrove Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 November 2016 End date: 9 November 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:	47

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

Maygrove Village is privately owned. Services are provided on the first floor of an attached aged care village complex. Maygrove Village Hospital services (Maygrove Care) has 50 beds which can be used for either hospital or rest home level care.

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, procedures, residents and staff files, observations and interviews with residents, family/whānau, two general practitioners, management and staff.

There are two areas identified for improvement related to short term care plans not being consistently developed and evaluation processes.

One area related to medication management has gained a continuous improvement rating.

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.
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The Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required. A community advocate visits the facility regularly.

There were no residents who identify as Maori residing at the service at the time of audit. There are no known barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist healthcare providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The organisation respects and supports the right of the resident to make a complaint. The service has a complaint register and the information is recorded to meet all the requirements of the standard. There were no outstanding complaints at the time of audit.

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.
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The organisation's philosophy, mission and vision statements are identified in the business plan. The board of directors ensures service planning covers business strategies for all aspects of service so the services offered meet residents' needs, legislative and good practice standards.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit process, complaints management, incident/accident reporting, annual resident surveys, restraint and infection control data collection. Quality and risk management activities and results are shared among management, staff, residents and family/whānau, as appropriate. Corrective action planning is well documented. The facility manager reports weekly to the board of directors or more frequently if any issues of a serious nature occur.

The day to day operation of the facility is undertaken by staff that are appropriately experienced, educated and qualified. Residents and family/whānau confirmed during interview that all their needs and wants 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.

Clinical records are integrated. The contents are individualised, meet current accepted practice for content and timeliness, and are stored securely including archived documents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Residents are admitted following a Needs Assessment and Service Co-ordination (NASC) assessment, to ensure access to the facility is appropriate. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Services are provided by suitably qualified and trained staff to meet the needs of residents. The registered nurses are supported by care and allied health staff including, a podiatrist, physiotherapist, pharmacist and four general medical practitioners. Shift handovers support continuity of care.

Residents have an initial nursing assessment and care plan developed by the registered nurse (RN) on admission to the service. After a full comprehensive assessment, the long term care plan is developed and implemented. All residents` records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis with the resident and family`s input.

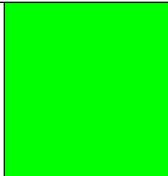
Residents and families interviewed reported being well informed and involved in the care planning process, and that the care provided is of a high standard. Residents are referred to other health providers as required, with verbal and written information provided.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are managed according to policies and procedures based on current good practice, and consistently implemented using an electronic system. Medicines are administered by registered nurses, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. The service has a four-week rotating menu which is approved by a registered dietitian. The kitchen has an `A grade` food rating with Auckland City Council. 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.
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The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substance.

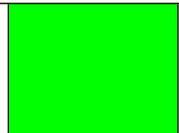
There are documented emergency management response processes which are understood and implemented by staff.

The building has a current building warrant of fitness and an approved fire evacuation plan. There have been no changes to the facility footprint since the previous audit.

The facilities meet residents' needs and provide furnishings and equipment that is regularly maintained and updated. All bedrooms are single occupancy. There is adequate toilet, bathing and hand washing facilities. Lounge and dining areas meet residents' relaxation, activity and dining needs.

The facility has central heating throughout. Opening doors and windows creates an air flow to keep the facility cool when required. The outdoor areas provide furnishings and shade for residents' use. Residents and family/whānau were happy with the environment provided.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. At the time of the audit, the service has no enablers in use. As the facility is on the first floor of a village complex the lift to get to the care unit has a key code for security.

There are nine residents, one of whom has two items approved, so there are 10 restraints in use. The restraints in use at the time of audit are bedside rails and chair lap belts. Appropriate and safe use of restraint, as set out in policy, is implemented by the

service. There is a process for determining restraint approval and ongoing education and competencies for staff. Educational content includes de-escalation techniques which are understood and implemented by staff as required.

Six weekly evaluations are conducted for each individual restraint in use and if restraint is continued the resident or family/whanau sign ongoing consent approval six monthly. Approved restraint is monitored according to risk. An annual quality review of the use of restraint and policy content was undertaken in January 2016.

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.
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The infection prevention and control programme, led by an enrolled nurse and the clinical manager aims to prevent and manage infections. There are terms of reference for the infection control committee which meets six weekly. Specialist infection prevention and control advice can be accessed from the District Health Board, community laboratory services, and the general practitioners as required. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and procedures and supported with regular education.

Aged care specific surveillance is undertaken, analysed, trended and results reported and fed back to staff at the staff meetings. Follow-up action is taken when required.

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	48	0	2	0	0	0
Criteria	1	98	0	2	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The service has developed policies, procedures and processes to meet their obligations in relation to the Code of Health and Disability Services Consumers` Rights (the Code). Care givers interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on residents` rights is included as part of the induction process for all new staff and is ongoing, as was verified in the training records sighted.</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>A detailed informed consent policy is in place. The service ensures informed consent is part of all care plans and contact with families. Every resident has the choice to receive services, refuse services and withdraw consent for services. If a resident is cognitively alert they will decide on their own care and treatments unless they indicate they want representation. Informed consent is closely linked with the Residents` Code of Rights and Responsibilities.</p> <p>The service provider ensures residents/family/enduring power of attorney (EPOA) understand documents that they are signing. The service maintains records to identify whether the EPOA has been activated for individual residents or are held for future needs. The `general` informed consent form, resuscitation authorisation, restraint and enabler consent form, and influenza vaccine consent were sighted. The caregivers and registered and enrolled nurses interviewed</p>

		demonstrated their ability to provide information that residents required for the residents to be actively involved in their care and decision-making. Staff interviewed acknowledge the resident's right to make choices based on information presented to them.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Pamphlets related to the Nationwide Advocacy Service were available near the reception. A poster by the dining room entrance details the contact details of a community advocate who visits at least every six weeks and meets new residents and existing residents who want to interact. The community advocate also provides a consumer perspective on the restraint management committee. Family members and residents were aware of the Advocacy Service, how to access this and their right to have support persons. Staff are aware of how to access the Advocacy Service and education was provided as evidenced in the education plan and staff records reviewed.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending outings, activities and entertainment. This is evident in the residents' files sampled. Visitors are welcome and the facility has very flexible visiting hours. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Maygrove Care implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system. During interview residents, family/whānau and staff reported their understanding of the complaints process. Staff confirmed they document verbalised complaints so all issues are accurately reflected and followed up by the facility manager. The service documents the nature of the complaint, the dates received and the actions taken to address any complaint received. Documented complaints information is used to improve services as appropriate. Complaints information is shared at staff meetings and with the board of directors as required. This is confirmed in meeting minutes sighted and during staff, director and management interviews. Complaints forms are on display and available in the main foyer. The service has a suggestion box which is checked daily and complaints can be placed in this at any time. There were no outstanding complaints at the time of audit and all complaints have been resolved

		<p>at facility level.</p> <p>There was one death referred to the coroner in July 2016. The documented dated 9 August 2016 states that no inquiry was opened and it was death by natural causes. This was reported to the Ministry of Health at the time of occurrence. (Confirmation letter from Healthcert sighted).</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with the registered nurse on admission. The Code is displayed in the entrance way and pamphlets are also in each resident's room. Information on advocacy services and how to make a complaint / feedback forms and a suggestion box is also available by the main reception.</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>Residents and families interviewed confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Families reported there was a positive atmosphere when they visit regardless of the time of day.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending to personal cares, ensuring residents information is held securely and privately). Any exchange of verbal information is managed so that others cannot hear. All residents have their own single occupancy rooms.</p> <p>Residents are encouraged to maintain their independence by going on outings with family in the community, community activities and attending activities of their choice. Each service plan included documentation related to the resident's abilities, preferences, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual culture, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff interviewed understood the service's policy on abuse and neglect, including the signs and symptoms, and what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for all new staff, and is then provided annually, as confirmed in the training records.</p>
<p>Standard 1.1.4: Recognition Of Māori</p>	FA	<p>The policies reviewed acknowledge the organisation's responsibilities to Maori residents in</p>

<p>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>accordance with the Treaty of Waitangi. The organisation is committed to identifying the needs of residents and ensuring staff are trained and capable of working appropriately with all residents in their care. The provision of culturally appropriate services and the identification and reduction of barriers to receiving services are part of the organisation's objectives which are documented in the Maori Health Plan.</p> <p>There are no residents who identify as Maori at the time of audit. The caregivers, and registered health professionals interviewed demonstrated good understanding of services that are in line with the needs of Maori residents and importance of whanau.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and family members verified, that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, requiring interventions and special needs were included in all care plans reviewed.</p> <p>Staff reported they received training in cultural awareness and this was evidenced in the education plan and training records sighted.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Two general practitioners interviewed also expressed satisfaction with the standard of services provided to residents.</p> <p>The staff records reviewed have job descriptions and employment agreements that have clear guidelines regarding professional boundaries and the expected staff code of conduct. The family and residents reported they are happy with the care provided.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from allied health professionals, such as the physiotherapists, podiatrist and other specialist services. Two physiotherapy assistants work with residents to implement the physiotherapy exercise / mobility plan for each resident. Applicable residents are referred to and seen by the community residential care pharmacists from the local DHB. The registered and enrolled nurses have access to regular ongoing education and records of this are maintained. Residents and family are invited to attend the residents' six monthly review meetings. Detailed assessment charts are used to document wounds and their progress in healing. The service has recently changed to an electronic medication management system (refer to 3.12.1).</p>

		<p>The two general practitioners confirmed the service sought prompt and appropriate medical intervention when required and staff were responsive and implemented their medical requests.</p> <p>Staff reported they receive in-service education on a regular basis.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirement of the Code.</p> <p>Interpreter services are available and accessible via the DHB when required. Staff knew how to do so, although reported this was very rarely required. Staff utilised a phrase board for a recent resident who had limited ability to communicate in English. This had been developed in conjunction with the resident's family. All current residents speak English.</p>
<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>Maygrove Village was built and is owned and operated by Hooper Developments. Currently it is the only facility owned by this group. Maygrove Village has a business plan in place which is reviewed annually by the board and monitored quarterly by management to measure progress towards meeting set goals. There are specific Care Unit goals which are set as part of the quality system in operation. Each of the committees which operate within the care unit, such as health and safety, infection control and restraint have individualised goals. The business plan identifies both strategic and workplace goals which show how services are planned, coordinated and delivered to meet residents' needs. The organisation's philosophy, mission statement and values are clearly documented and the facility manager confirms they underpin all planning processes.</p> <p>On the day of audit, the service had 47 residents. One was rest home level care and 46 were hospital level care.</p> <p>There is a facility manager in place who is experienced in aged care and has been in the role since March 2015. She has worked at Maygrove Care since 2007. The facility manager is supported by a clinical nurse manager, nurse advisor and a team of registered nurses and enrolled nurses. The facility manager holds a current nursing practising certificate.</p> <p>All the members of the management team maintain education and training related to their roles by attendance at conferences, in-service education, off-site training and via internet education.</p>

		Accountability and responsibilities are clearly described in the job descriptions sighted.
<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>During a temporary absence of management staff, the service ensures the day-to-day operation of the service is managed effectively and efficiently by staff who fill in. This is achieved by staff being upskilled to perform the roles they are asked to undertake.</p> <p>During a temporary absence of the facility manager, the clinical nurse manager undertakes the role and the most senior RN performs the clinical nurse manager's role. During interview, the clinical nurse manager stated they are supported by the nurse advisor and a member of the BOD as required.</p> <p>Staff confirmed that there is no disruption to services when the facility manager is away.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Maygrove Care has a quality and risk management system which is understood and implemented by service providers. This includes the update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and management, restraint and complaints management.</p> <p>If an issue or deficit is found a corrective action is put in place to address the situation. Corrective actions are developed and managed by the committee which relates closest to the issue. For example, infection control management is undertaken by the infection control committee. Quality information is shared with all staff via the handover process on each shift and/or by memos, in the staff communication diary, in meeting minutes and statistical data reporting. This is verified during staff interviews. Strategic and workplace goal achievements are measured and reported on quarterly to the board.</p> <p>The policies reviewed reflected legislative and good practice requirements.</p> <p>Quality data is trended against previously collected data. The annual review of all quality planning and data occurred in January 2016. This linked to the quality and risk management system in place.</p> <p>The annual quality review includes the maximisation of resources, strategies to reduce the risk of adverse outcomes, ways to improve resident and staff safety, promotion of appropriate cultural interventions and ensuring evidence based information is generated in policies. The annual resident satisfaction survey results are also used to inform the planning processes. The results of the 2016 survey gained an 86.5% overall satisfaction. Issues raised have been addressed by the service.</p>

		<p>Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management. Staff verbalised examples of quality improvements made such as the decrease in medication errors owing to the introduction of an electronic medicine management system.</p> <p>Actual and potential risks are identified using the quality and risk planning processes. Newly found hazards are discussed, monitored and managed via the health and safety committee. Staff confirmed that they understood and implemented documented hazard identification processes. The hazard register sighted was up to date.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Adverse event reporting, as identified in policy, is implemented by the service. The facility manager confirmed their awareness of the organisation's requirement related to statutory and or/regulatory reporting obligations including the need to report pressure injuries under section 31 of the Health and Disability Services (Safety) Act 2001.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information along with any corrective actions is shared at staff meetings as confirmed in minutes sighted.</p> <p>Documentation in residents' files and the 2016 incident and accident forms reviewed identified that all issues reported had corrective actions put in place when required. One week following the corrective action being put in place a review and evaluation is undertaken to ensure all requirements are met and to measure the outcome of the procedures implemented. The incident and accident form is then signed off by either the facility manager or the clinical manager. Serious harm incidents are reported to the board immediately. This is confirmed in emails sighted.</p> <p>Family/whānau notification is clearly shown in documentation and confirmed during family/whānau interviews.</p> <p>Management reported during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. All incidents are evaluated by the health and safety committee to identify areas for improvement. The service is pro-active in the identification of areas of risk and this is supported by them obtaining a tertiary rating for Work Safety Management Practices from Accident Compensation Corporation (ACC) in September 2016.</p>
<p>Standard 1.2.7: Human Resource Management</p>	FA	<p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. This is confirmed in the staff files reviewed. All roles have job descriptions that describe staff responsibilities and accountabilities. Staff complete</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>an orientation programme with specific competencies for their roles. The orientation/induction process is for up to two weeks and rosters viewed and staff interviewed confirmed that during this period the staff member is not counted as an active staff member on the floor. Two recently employed staff stated the orientation is giving them a very good understanding of expected procedures and that they are not asked to perform any role they are unsure of. New staff are mentored by senior staff on each shift.</p> <p>Documentation in the staff files reviewed confirmed some competencies, such as medication management, fire and emergency and restraint are reviewed annually.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. Employment processes included reference checking and annual staff appraisals. (All appraisals were up to date for the staff files reviewed).</p> <p>The education calendar sighted for 2016 identifies that staff undertake training and education related to the roles they undertake. Topics covered in annual training and education relate to age care and health care services. Members of the management team also attend workshops and seminars specific to management related topics. Education occurs both on and off site.</p> <p>Resident and family/whānau members interviewed, identified that residents' needs are met by the service. This is also supported in the resident satisfaction survey results sighted for 2016.</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>	<p>FA</p>	<p>Policy identifies staffing levels and skill mix are maintained to meet residents' needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified and experienced staff are on duty to provide safe and quality care. The service undertook an analysis of incident times which showed that most falls occurred at specific times of the day. Follow up included the introduced an additional staff member to cover both the identified times for morning and afternoon shift. This shift is known as a swing shift and is shown on the rosters reviewed.</p> <p>Rosters sighted showed that staff were replaced for sickness and annual leave. This was confirmed during interview with staff and management. Staff reported they had adequate time to complete all required tasks to meet residents' needs. There is at least one registered nurse on all shifts.</p> <p>Resident and family/whānau members interviewed stated all their needs have been met in a timely manner.</p> <p>The service has dedicated cleaning and laundry staff seven days a week. The activities coordinator works 30 hours per week and there are two physiotherapy assistants covering 54</p>

		hours per week. The physiotherapy assistants work under the guidance of a physiotherapist who works six hours per week. A contracted occupational therapist undertakes resident assessments when required and is involved in staff education.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on all records reviewed as the unique identifier. All necessary demographic, personal, clinical and health information was fully completed in the seven residents' records randomly sampled for review. Clinical notes were current and integrated with GP and allied health professional notes. Records were legible with the name and designation of the person making the entry identifiable. A register of employee names, designation and signatures is maintained. Medication records are now electronic.</p> <p>Archived records are held securely on site and are readily retrievable. Residents' records are held for the required period before being destroyed. No personal or private information was on public display during the audit. Some records, including previous bowel charts and one neurological monitoring form, were not able to be located. It was thought this information had been removed for archiving although could not be located. One resident's file contained a DHB discharge summary from another resident. These were isolated events as all other documents were available when requested and located in the correct resident's file.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has an admission/enquiry form that records the pre-admission information. There is a resident's welcome brochure for all enquiries. Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service. The service provides rest home care and hospital level care.</p> <p>Family members interviewed on this topic stated they were very satisfied with the pre-admission and admission process and the information that had been made available to them in a kind and timely manner. Records reviewed contained the information record, assessments and signed admission agreements in accordance with contractual requirements.</p> <p>A register is maintained of all enquires and facility occupancy on a day by day basis.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort if appropriate. A transfer/discharge summary is completed when facilitating an urgent or planned transfer from Maygrove Village Hospital to acute care services, such as the DHB or another aged</p>

<p>coordinated transition, exit, discharge, or transfer from services.</p>		<p>residential care facility. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including a copy of the medication record (with any known allergies documented) is provided for the ongoing management of the resident. All referrals are documented in the progress records.</p> <p>One family interviewed had experienced their relative being transferred from the DHB to this facility and reported that they were kept informed before and during the transfer. Another resident required transfer to the DHB for investigation and management following a fall. The resident and family member verified they were kept well informed at all stages.</p>
<p>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.</p>	<p>FA</p>	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. Medicine standing orders are current.</p> <p>Medicines for residents are received from the pharmacy in a pre-packed delivery system and are checked on arrival. A safe medicine management was observed during the audit. Residents are informed of the names of each medicine being administered and the expected action. The resident had the right to refuse offered medicines, and in this event the rationale was noted. Long term or short term changes in medicines prescribed are discussed with the resident or their family.</p> <p>Medicines are locked away in a secure room. Three medication trolleys are used for the medication round (one for each wing). Medicines that require refrigeration are stored in a separate fridge. Temperature monitoring of the fridge is completed and records were available. Controlled drugs are managed in accordance with legislative requirements.</p> <p>There is a specimen signature register maintained. Resident photo identification is on all individual resident's records reviewed.</p> <p>Three residents are self-administering medications. There is a three monthly risk assessment for a resident who has been approved by the GP and the clinical manager to administer their own medications.</p> <p>There are documented competencies for nursing staff and the limited care staff designated to administer medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and</p>	<p>FA</p>	<p>The food services is provided on site by the Maygrove Village catering staff. The catering manager has worked at this facility for 14 years and is assisted by 14 staff (including kitchen hands). Eleven staff have completed food safety training. The menu is a four week seasonal</p>

<p>nutritional needs are met where this service is a component of service delivery.</p>		<p>rotating menu. The current menu has been reviewed by a qualified dietitian. The service holds an 'A grade' food rating with the Auckland City Council with an expiry date of 30 September 2017.</p> <p>All aspects of production, preparation, storage and disposal comply with current legislation and guidelines. It is observed the area where food is plated for meal service is cluttered and contains the kitchen washing machine and drier.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility by the registered nurse and a dietary profile is developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs, is available. Nutritional supplements are also readily available and used.</p> <p>Resident satisfaction with meals is verified by resident and family interviews. The main meal is provided midday. Residents are now clearly given a choice for alternative options in the evening if they do not want the planned meal. Records are retained of the resident's evening meal choice.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner. There is sufficient staff on duty in the dining room at meal times to ensure appropriate assistance is available to residents as needed. Where preferred residents can eat their meals in their room and staff assistance is also provided as required.</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>If a referral is received but the prospective resident does not meet the entry criteria or there is full occupancy, the enquirer is advised to ensure the prospective resident and family are supported to find an appropriate care alternative, or, alternatively is waitlisted for a bed to become available. In the event the prospective resident is wait listed, there is regular communication with the prospective resident and or their family member until a bed becomes available or another facility has been selected.</p> <p>If the needs of a resident change and they are no longer suitable for the current services offered, a referral for reassessment to the NASC is made and a new placement found. This is undertaken in consultation with the resident and family/whānau. The registered nurses advise this has occurred when a resident was identified as needing a secure dementia level care</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools such as falls risk, skin integrity, skin tear risk, pressure area risk, and nutritional assessment. These tools are used during the admission processes and reviewed at least six monthly or sooner when new deficits</p>

<p>requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>are recognised. The sample of care plans reviewed had an integrated range of resident related information. All residents' records reviewed have a completed interRAI assessments completed by one of the three registered nurses who hold current interRAI competency. This included a resident who had been admitted within the last 21 days. A schedule has been developed by the clinical manager for interRAI assessments on admission and for the six monthly reviews.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>The residents' initial and long term care plans reflected the support needs of residents. Short term care plans are not consistently developed when the resident has short term changing care needs including infection or pain. Care plans evidence service integration with progress records, activities records, medical and allied health professionals' entries are clearly written, informative and relevant.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. This includes where short term care plans had not been developed for short term or new events that were not included of the long term care plan. Interventions were provided to the sampled residents for wound care, pressure area management, confusion, pain, weight loss, monitoring a resident after a fall and treatment of infections.</p> <p>The service has adequate wound care and continence supplies to meet the needs of the residents. Observations on the day of audit indicated residents are receiving appropriate care to meet their individual needs. The clinical manager and nursing team discussed the care plans which are comprehensive. The caregivers interviewed reported that the care plans are accurate and are kept up-to-date and are able to be followed.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is developed and implemented by the activities coordinator who herself regularly attends a community based day programme for the aged to gain ideas. The weekly activities plan is provided in advance to all residents. Daily records of attendance are maintained.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly as part of the six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests</p>

		<p>identified in assessment data. The activities reflect residents` goals, ordinary patterns of life and include normal community activities, individual group activities and one on one activities as needed. Examples included music /entertainment sessions, bingo, monthly birthday parties, arts and crafts, manicures and pedicures, outings, and family events. Participation in any activity is voluntary. There is a church service occurring weekly with four different religious denominations providing onsite activities for consenting residents. Wi-Fi is available to residents. There is a library on site, videos are available, and a movie internet streaming service now provides residents with expanded movie choice. Residents can have a telephone in their room.</p> <p>Resident and family surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they were satisfied with the programme and their participation is encouraged but not forced.</p> <p>Families are able to attend some activities. The families interviewed reported their relatives enjoyed the range and variety of activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>A range of appropriate assessment tools are available. Assessments are consistently completed for relevant aspects of care, excluding the use of objective pain assessment tools when additional pain relief (including opioids) is provided to the resident.</p> <p>The families reported that they can consult with staff and/or the GP if they have any concerns or there are changes in the resident`s condition. They report that changes in the resident`s condition are identified and followed up in a timely manner and this was sighted during audit. Family communications are detailed within the progress notes of the residents` files sampled.</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>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service provider. If the need for non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of any referrals were sighted in residents` records, for example, referrals to radiology, speech language therapist, palliative care services, the WDHB aged residential care pharmacist, community mental health services, and DHB outpatient specialist`s services.</p> <p>The GP interviewed reported that appropriate referrals to other health and disability services are well managed at this service. The resident and family members interviewed identified they are always consulted and give agreement prior, or on occasions have declined to have referrals made.</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>	<p>FA</p>	<p>Policy describes safe and appropriate storage and disposal of waste substances and this is implemented. Yellow sharps bins are used for the safe disposal of medical waste, such as needles. Staff report their understanding of safe disposal processes.</p> <p>Chemicals are stored securely. Chemicals are labelled in bottles provided by the contracted company who supplies them. Safety data sheets were sighted for the chemicals in use. There is a chemical products reference chart on the wall in the area where chemicals are stored. A six monthly audit of chemicals and the safety data sheets is undertaken to ensure the complies with this standard. A chemical hazard register kept at the reception area, in the laundry and in the cleaner's room.</p> <p>Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves as required.</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>	<p>FA</p>	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which expires 16 June 2017.</p> <p>There is a process in place to identify and manage maintenance. The care unit shares the maintenance and gardening team with the village and external contractors are used as required. Electrical safety testing occurs annually and was completed in June 2016 by a registered electrician. Clinical equipment is tested and calibrated by an approved provider at least annually and was last undertaken in September 2016.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip and walking areas are kept clear of obstructions. Monthly environmental audits are undertaken and corrective actions are put in place when required.</p> <p>The service identifies planned annual maintenance. Day to day maintenance is undertaken as required.</p> <p>Outdoor areas located on the ground floor and a deck off the main lounge have appropriate seating and umbrellas for resident use. Resident use of these areas was observed on the days of audit.</p> <p>Interviews with residents and family/whānau members confirmed the environment is suitable to meet their needs.</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 and shower facilities. All bedrooms have toilet and hand basin ensembles and 15 bedrooms have full ensembles. There are centrally located shower areas where required and separate staff and visitor toilet facilities. Hot water temperatures are monitored to ensure they remain within safe limits for residential care.</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 are of a size which allows enough space for residents to mobilise safely with or without assistance. 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 are happy with their personal space.</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>Residents are provided with adequate areas to meet their relaxation, activity and dining needs. There are three lounge areas, one in each wing. There is a separate centralised dining area. The service has a furniture replacement programme to ensure common areas and furnishings are kept in a good state of repair. Since the previous audit the main lounge has had sun shade blinds and light emitting diodes (LED) installed.</p> <p>There is a dedicated physiotherapy room which is very well equipped. Activities are undertaken in the main lounge and in the dining area. This was observed on the days of audit.</p> <p>Residents and family/whānau voiced their satisfaction with the environment.</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. The laundry is very well set out and has a clean and dirty entrance. The equipment is regularly maintained. Staff stated they inspect the linen post laundering to ensure it is clean and they understand the need to place the washing machines on correct settings when washing items. The correct use of chemicals is monitored by the chemical supply company three monthly and a report is kept at the facility. (The compliance and safety certificate was sighted).</p>

		<p>There is an ironing press machine in the laundry and sewing machine for minor repair work.</p> <p>The cleaners have specific trollies to carry all cleaning items and they are stored in secure areas when not in use.</p> <p>During interview, residents and family/whānau confirmed they are very happy with the cleaning and laundry services provided.</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>	FA	<p>Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plan is reviewed annually as part of the quality process. This is one of the roles undertaken by the health and safety committee and it last occurred in May 2016. Emergency fire equipment is checked annually by an approved provider (February 2016) and there is an evacuation plan which was approved by the fire service in August 2007. There have been no changes to the facility footprint since this time. Six monthly fire evacuations are undertaken with the last one occurring in May 2016. No follow up actions were required.</p> <p>Emergency supplies and equipment include food and water, first aid kits, outbreak supplies and a civil defence box. The contents are rotated regularly so that they do not expire.</p> <p>Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ and cooking. The service has a process in place for alternate food preparation and delivery should it be required. The medication system can be operated via the emergency power or can convert to manual use if there is a prolonged power cut.</p> <p>The security arrangements involve staff ensuring the doors and windows are locked upon dusk. There are specific security staff employed from 11pm to 7am who check the grounds and building regularly during these hours. Staff carry cell phones on all shifts to ensure they can contact emergency services should they be required.</p> <p>Call bells are located in all resident areas. Resident and family/whānau interviews confirmed call bells were answered in an acceptable timeframe. The facility manager monitors response times as part of the quality processes.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an</p>	FA	<p>All resident areas have at least one opening window which provides natural light and ventilation. The facility has central heating via ceiling vents and heat pumps have been installed in common areas such as the lounge and dining areas to keep the areas cool in summer.</p> <p>Residents confirmed that the facility is maintained at a comfortable temperature throughout the</p>

environment that is maintained at a safe and comfortable temperature.		year.
<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>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a current infection control manual, developed at organisational level. The infection control programme and manual are reviewed annually.</p> <p>Residents with a multi drug resistant organism (MDRO) have this clearly detailed in the care plan.</p> <p>An enrolled nurse is the designated IPC co-ordinator and works with the support of the clinical manager. The role and responsibilities of the IPC coordinator are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager and tabled six weekly at the infection prevention and control meeting. The infection prevention and control committee includes the infection prevention and control coordinator, clinical manager, a registered nurse, a caregiver, the activities coordinator, a laundry employee and a cleaner.</p> <p>Staff and residents are offered an annual influenza vaccination. Thirty five residents and 29 staff received this vaccine in 2016. Staff interviewed understood their responsibilities to prevent the spread of infection. Appropriate personal protective equipment (PPE) is available and observed to be in use. There have been no outbreaks of infection since the last audit.</p> <p>Compliance with key aspects of policy is monitored via audit.</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 infection prevention and control coordinator (IP&CC) has appropriate skills, knowledge and qualifications for the role, and has been in this role for about 18 months. The IP&CC has completed some recent training provided by an infection prevention and control consultant as verified in the training records sighted. If required expert advice can be sought from the community laboratory and/or the general practitioners, and the infection prevention and control team at the local DHB. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The clinical manager is also available on a day to day basis for advice and support.</p> <p>The infection prevention and control coordinator confirmed at interview the availability of resources to support the programme and management of any outbreak of an infection (if required).</p>

<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>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed annually and scheduled throughout the year. All policies scheduled for review year to date have been reviewed. A copy of all the policies are kept in reception for staff to access. Where there is significant change in the content of a policy, or a new policy has been developed, staff are required to read and sign the policy.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good handwashing techniques and use of disposable gloves, as appropriate. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>	<p>FA</p>	<p>The staff education plan includes infection prevention and control. This commences during orientation and has continued in the ongoing education programme. The education planner for 2016 has been implemented. The infection prevention and control coordinator provides education sessions. A record is maintained of all infection control education provided.</p> <p>Education with residents is generally on a one-to-one basis and included mostly handwashing advice, personal hygiene and the prevention of urinary tract infections. The education is documented in the resident's record.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for a long term care facility. This includes urinary tract infections, wound infections, fungal infections, eye infections, chest infections, Methicillin Resistant Staphylococcus Aureus, and other infections. When an infection is identified a record of this is documented on the infection reporting form, and also detailed on the infection register in the applicable resident's file. The infection prevention and control coordinator reviews all reported infections and maintains a register including the name of the resident, the type of infection, the results of laboratory investigations (if applicable), the treatment and the outcome.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via a display of surveillance data (graphed) in the staff tearoom, and at the time and infection is identified by discussion during staff handover.</p> <p>There have been no outbreaks of infection since the last audit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policy states that at Maygrove Care any form of restraint is a serious intervention and therefore every effort to minimise the use of restraint is made. Restraint it is only applied to enhance or maintain the safety of the resident, staff or others. The use of enablers is voluntary and the least restrictive option to meet the needs of residents.</p> <p>At the time of audit there are no enablers and nine residents with approved restraint. One resident has two approved restraints, one is a chair lap belt and the other is bedside rails. The number of restraints in use has decreased since the same time in 2015 when the service had 17 restraints.</p> <p>It was noted that the service call walking frames and walking sticks enablers and family/whanau sign for the use of these items. During discussion with the facility manager/restraint coordinator it was determined that the above mentioned items enhance resident movements and do not restrict them. Therefore, they do not fall under the definition of an enabler.</p> <p>The service has documented environmental restraints which is recorded as the four stairwells and the lift which serve as exits out of the care area. The stairwells are locked with an instant release mechanism button on the wall adjacent to each stairwell to allow quick release of the doors in an emergency. The lift has a code to allow it to operate from the care area to the exit on the ground level. This information is given to family/whanau and the resident upon entry to the service. Resident files contain a signed consent which stated they were fully informed of this prior to entry. Residents were seen coming and going via the lift on the days of audit.</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>	<p>FA</p>	<p>Restraint approval and process as set out in policy are implemented by the service. There is a restraint committee and the resident, family/whanau and GP are always involved in the decision to apply restraint. This is confirmed in four resident file reviews undertaken for restraint use. At the time of audit, the only restraints in use are bedside rails and chair lap belts.</p> <p>Restraint is reviewed if the resident's condition changes to determine if restraint is still appropriate and/or six monthly during the resident evaluation process. The resident and/or family/whanau sign to say this has been discussed at the six monthly evaluation.</p>
<p>Standard 2.2.2: Assessment</p>	<p>FA</p>	<p>The restraint assessment/authorisation form is used to indicate if restraint is required. It covers all aspects of this criterion. If there is an incident related to restraint use a full re-assessment is</p>

<p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>undertaken and discussions are then held with the restraint committee. Two incidents followed up during audit show that one bedside rail was discontinued when a resident climbed over the top of the bedrail. The second incident involved a resident who was able to get their leg out of the bedside rail. Following a full review this restraint remained in place as the resident has involuntary movements owing to their medical condition. (There were bedside rail protectors in place when the incident occurred. (Both incidents were clearly documented, evaluated and show the outcomes of the review process).</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>Approved restraint is only put in place once alternative interventions have been considered. These interventions are documented on the restraint approval forms. All restraint is approved by the restraint committee prior to being used.</p> <p>The frequency of monitoring is undertaken according to the identified risk to the residents but never less than two hourly. The restraint coordinator determines the monitoring timeframes from the information gathered by assessment and during staff discussion.</p> <p>All restraints are detailed in the restraint register to an auditable standard.</p> <p>Staff interviewed confirmed their understanding and knowledge related to safe restraint use.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>All restraint use is discussed at the quality meetings as identified in minutes sighted. The continued use of restraint is part of the resident's six monthly evaluation of care and this is documented via interRAI, and clearly shown on the resident's care plan. If restraint is no longer required, it is discontinued. Family/whanau are made aware of any changes in the need for restraint.</p> <p>The restraint committee review restraint procedures six weekly or sooner if required. This is documented in restraint committee meeting minutes. The restraint coordinator (RN) also monitors staff education to ensure staff have up to date knowledge and understanding of safe restraint use. Restraint education occurs during orientation and ongoing at least annually. Restraint education is a compulsory educational subject for Maygrove care unit staff.</p> <p>Challenging behaviour education occurred in October 2016 and restraint education and questionnaires were completed in July 2016.</p>
<p>Standard 2.2.5: Restraint Monitoring</p>	<p>FA</p>	<p>The quality committee review all restraint processes and usage at each meeting. Trends are</p>

<p>and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>		<p>shown using quality data which gives comparative data to previous restraint use. Care plans are reviewed twice yearly to ensure restraint use is clearly and correctly documented. If corrective actions are required they are followed up by the restraint coordinator. The policies and procedures and staff educational content are fully reviewed in January each year. This is shown in documentation sighted.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<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 Low	<p>The residents' initial and long term nursing care plans reflect the support / care needs of each resident, and the outcomes of the integrated assessment process and other relevant clinical information. Short term care plans are not consistently developed when the resident has short term changing care needs including from an infection, or acute exacerbation of pain. For example, one of the residents audited using tracer methodology did not have short term care plans for some of the reported infections in 2016, although appropriate treatment was provided. While staff are managing a resident's increased pain, a clear plan to guide staff assessment and intervention had not been documented. Short term care plans were not available for two other residents who had been recently treated for an infection. Short term care plans were consistently developed when a resident had a skin tear or wounds in the sampled files.</p> <p>Residents and families reported participation in the development and ongoing evaluation of the individual care plans.</p>	Short term care plans are not consistently developed when residents have changing care needs including infections and episodes of pain.	<p>Provide evidence that short term care plans are consistently developed when residents have changing care needs.</p> <p>180 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 Low</p>	<p>The residents' records reviewed had a documented evaluation that is conducted within the past six months. Evaluations are resident focused and indicate the degree of achievement or response to support interventions and progress towards meeting the desired outcomes. If a resident is not responding to the interventions being delivered, or their health status changes, then this is discussed with the GP. Residents' changing needs are clearly described in the care plans reviewed. Wound assessments were documented on template forms and reviewed at least daily. Neurological observations were undertaken following an unwitnessed fall. Bowel charts were maintained.</p> <p>Short term care plans are used for wound care, changes in food and fluid intake and skin care and/or pressure area care when needed. They are not consistently available for when a resident had an infection or elevated levels of pain (refer to 1.3.5.2). One resident is currently having their pain levels evaluated hourly over a 24 hour period as requested by the resident's general practitioner. However, objective pain assessments are not consistently undertaken before or after three other residents are given additional pain relief, including opioids, for reports of increased pain. This included one of the residents audited using tracer methodology.</p> <p>The caregivers interviewed demonstrated good knowledge of short term care plans and reported that these are communicated during handover.</p>	<p>Objective pain assessments are not consistently undertaken when residents are given additional medications for episodes of pain.</p>	<p>Provide evidence that pain medication use is evaluated for effectiveness.</p> <p>180 days</p>
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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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<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</p>	CI	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, medicine reconciliation, processes when an error occurs as well as use of ‘over the counter’ medications and herbal supplements. The sighted policies meet the legislative requirements of best practice and have been updated to reflect changes in practice</p>	<p>The service has moved to use of an electronic medicine management system in July 2016. Applicable organisation policies and procedures were updated to reflect the new service. Staff, the general practitioners and pharmacy were trained prior to the change. Staff were required to complete an updated medicine competency reflecting the new procedures. Three months after implementation an evaluation has occurred of the new system. Feedback from staff notes the system is user friendly. The prescribers can remotely prescribe or amend medicine records following conversations with the RNs (eg, for a resident with an infection). This has enhanced the timeliness of prescribing occurring and reduced the use of verbal orders. Once the ‘Wi-Fi’ problems related to black zones was addressed the time spent undertaking the medicine rounds has reduced enabling the nurses more time to complete other activities. Further work is planned to optimise ‘Wi-Fi’ coverage within the building. Medicine records are legible and clear. There are no issues reading or interpreting the general practitioner’s orders. The use of the dash board function has allowed at a glance a review to ensure medicine records are reviewed by the general practitioner at least three monthly. Resident refusal of medicines is easily traceable as is the use of pro re nata medicines for discussion at GP reviews and the six monthly care plan reviews. Aspects of this projects evaluation have been communicated to the product</p>

<p>reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>since the service moved to an electronic medicine management system.</p> <p>The 14 medicine records randomly reviewed on the electronic system used have been reviewed by the GP at least three monthly. All prescriptions sighted were accurately documented by the GP and checked by the pharmacist. Any allergies/sensitivities are flagged on this system.</p>	<p>supplier via email in order to further improve processes.</p>
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End of the report.