

M & K Atkins 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](#).

The specifics of this audit included:

Legal entity:	M & K Atkins Limited
Premises audited:	The Waratah Retirement Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 March 2017 End date: 28 March 2017
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:	56

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

The Waratah Retirement Home provides rest home level care for up to 58 residents. The service is a family owned and operated service.

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

The four areas identified for improvement from the previous audit related to documenting open disclosure, the analysis of quality data, evidencing care planning and documentation related to the indications of use of 'as required' medications have all been addressed. There is one new area for improvement related to other aspects of medication management.

Feedback from residents and family/whānau members was positive about the care and services provided.

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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Communication with residents is open and honest and reflective of the service's open disclosure policy. The service implements processes for contacting interpreting services when this is required.

The service has policies and procedures in place which identify how complaints are to be documented, reviewed, followed up and addressed. There is an easy to access and use complaints system. The complaints register records all complaints, dates and actions taken. There are no open complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The management team ensures that business and strategic planning strategies are in place, covering all aspects of service delivery. The goals and objectives are updated annually and show how services are planned and coordinated to meet residents' needs. The goals are reviewed at the quality meetings.

One of the owners is the manager and is responsible for the overall management of the service. The owner/manager is supported by a clinical nurse leader who is a registered nurse.

The service has quality and risk management systems in place, covering all aspects of service delivery. The quality data and results from internal audits are collated, analysed and evaluated, this includes the adverse event reporting system. When shortfalls

are identified, a corrective action process is implemented. Documented quality and risk management activities results are shared among staff and residents/family as appropriate.

The day to day operation of the facility is undertaken by staff who are appropriately experienced, educated and qualified.

The service implements documented staffing levels to ensure contractual requirements are met and to meet residents' needs.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Registered nurses are responsible for the development of care plans with input from the residents, staff and family/whanau representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and contractual requirements.

Planned activities are appropriate to the residents assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

A medication management system is in place and medication is administered by staff with current medication competencies. All medications charts are reviewed by the GP every three months.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

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.

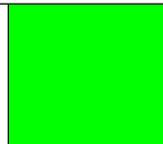


Standards applicable to this service fully attained.

There is a current building warrant of fitness in place. There have been no changes to the current layout of the service since the last audit.

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.

There are clear and comprehensive documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing restraint education.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There is a monthly surveillance programme, where infections are collated, analysed and trended with previous data. Where trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings.

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	15	0	0	1	0	0
Criteria	0	38	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission to the service. The complaints information has been revised, with the external advocate providing information and education sessions with residents and families. Forms are displayed and available at the entry to the facility.</p> <p>The complaints register reviewed contained all complaints, dates and actions taken. The complaints from 2016 were sampled, there were no recorded complaints to date in 2017. Each complaint is documented and completed within the required timeframes. Action plans show any required follow up and improvements have been made where possible. Complaints are reviewed at the continuous quality improvement (CQI) meeting. Staff interviewed confirmed understanding of the complaint process and what actions are required.</p> <p>There has been an external complaint made through the district health board (DHB) since the last audit. The improvements have been implemented and signed off by the DHB.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>The previous audit identified that not all incident/accident forms recorded that the family had been notified. This is now addressed. Residents and family members stated they are kept informed about any changes to their relative's status, are advised about any incidents or accidents and outcomes of regular and urgent</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>There is a process in place to access interpreter services as required. All residents could speak and communicate effectively in 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>	<p>FA</p>	<p>The service is a family owned business. The service provides residential aged care at rest home level of care for up to 58 residents. At the time of audit there were 56 residents. All current residents are assessed at rest home level of care. The manager reports that when there is a temporary increase in resident needs, then staffing and resources are increased to meet these changed needs.</p> <p>The strategic business plan, which is reviewed annually, outlines the purpose, values, scope, direction and goals of the organisation. Objectives and goals are set each year with short term and longer term objectives for the year. The monthly continuous quality improvement (CQI) meetings review the ongoing progress with meeting the goals and objectives.</p> <p>The management team consists of six members, who have clinical, non-clinical and quality roles. One of the owners is also the overall manager of the service. The owner/manager is support by a clinical team leader, who is a registered nurse with a current practicing certificate. The responsibilities and accountabilities are defined in a job description and the quality plan. The manager and clinical team leader have attended over eight hours of education in the past year related to aged care management. The owner/manager and clinical team leader both demonstrated knowledge of the aged sector, regulatory and reporting requirements and maintain currency through attendance at conferences, ongoing professional development and membership with an aged care association.</p> <p>The residents and families reported satisfaction with the care and services provided at the service.</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</p>	<p>FA</p>	<p>Previous audit identified that not all internal audits conducted documented the collation, analysis and evaluation of the findings. This is now addressed.</p> <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes and clinical incidents including infections.</p> <p>The quality and risk system is monitored through internal auditing and workplace inspections. The CQI meeting minutes and internal audits sampled confirmed regular review and analysis of quality data and key performance indicators. The related information is reported and discussed at the staff meetings and actions</p>

<p>principles.</p>		<p>are required to be implemented, this is also discussed at the staff handover. Staff reported their involvement in quality and risk management activities through audit activities and results being shared with them.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed overall satisfactions (excellent, very good and good results) at 99%. There were comments regarding food and activities, with actions taken in response to the results. A summary of the results was provided to residents and families.</p> <p>The policies and procedures have a cycle for review, with policies and procedures of a high risk reviewed more frequently. Policies and procedures are also updated to reflect any changes in legislation and best practice. The policies and procedures are reviewed through the CQI team. Staff are notified and sign that they understand any changes in policies and procedures. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff only have access to the current version.</p> <p>The quality manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The quality manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The service has a work place safety management plan and has been assessed by ACC at the tertiary level.</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>	<p>FA</p>	<p>Staff document adverse and near miss events on the electronic accident/incident record. A sample of incidents showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the health and safety meetings. The summary and actions implemented are also summarised at the CQI meeting. The data is used to make improvements at the individual resident level (such as changes in care planning) and the organisational level (improvements in equipment and processes).</p> <p>The owner/manager and quality manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification made to the Ministry of Health since the previous audit. This was a pressure injury that was not facility acquired.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates, where required.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records sampled show documentation of completed orientation. A performance review is conducted after the initial orientation/induction period then annually. One</p>

<p>practice and meet the requirements of legislation.</p>		<p>of the six staff files sampled did not evidence a performance review has been completed within the past year, this does not reflect a systemic issue.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. In-service education and training is provided at least monthly, presented by staff within the service or external specialists. Staff are encouraged to attend external education. Education sessions have been conducted on skin management and the pressure injury prevention management programme in 2016. There are three trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. One other registered nurse is booked on the training. Attendance records sampled demonstrated completion of the required training.</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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and families interviewed supported this. Observations and review of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty each shift has a current first aid qualification.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There is a documented policy in the management of the medication system. The service uses pre-packed medication packs that are checked by the RNs on delivery. The controlled drug register is current and weekly stock takes are completed as sighted and an improvement is required in doing six monthly stock takes per policy. All medications are stored appropriately. There were expired medications that needed to be returned to the pharmacy.</p> <p>There were no residents self-administering medication at the time of the audit. There is a policy and procedure for self-administration of medication if required.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted.</p> <p>An improvement is required for the medicines management system to comply with legislation, protocols and guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>Meals are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the</p>

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>cook confirmed awareness of dietary needs of the residents. The nutritional needs are provided in line with recognised nutritional guidelines appropriate to the residents at the service. The resident's dietary assessments are developed on admission which identifies dietary requirements, likes and dislike and reviewed as needed. Supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates were on all containers and records of temperature monitoring of food, fridges, freezers and chiller are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. All decanted food had use by dates recorded on the containers and were current.</p> <p>The residents and family/whanau interviewed indicated satisfaction with the food service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The documented interventions in short term care plans and long term support care plans are sufficient to address the residents assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift. Adequate clinical supplies were observed and the staff confirmed they have access to enough supplies. Residents and family/whanau members interviewed reported satisfaction with the care and support they are receiving.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The planned activities are meaningful to the residents' needs and abilities at Waratah Retirement Home. The activities programme covers physical, social, recreational, spiritual, intellectual, emotional and cultural needs of the residents. The activities are modified as per capability and cognitive abilities of the residents. The activities coordinator develops an activity planner which is posted on the notice boards and white boards respectively. Residents' files have a documented activity plan that reflects their preferred activities of choice. Over the course of the audit residents were observed engaging in a variety of activities. The residents and family/whanau reported general satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident's long term care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Family/whanau and staff input is sought in all areas of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.</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>There is a current building warranty of fitness displayed expiring June 2017. There have been no changes to the layout of the building that has required the approved evacuation scheme to be amended.</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 long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. There are standardised definitions for the identification of infections. The infection prevention and control coordinator reviews all reported infections and these are documented.</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 through regular staff meetings and at staff handovers. The analysis is also tabled at the health and safety and CQI meetings. Data is benchmarked externally with other aged care providers. Benchmarking has shown that infection rates in the facility are below average for the sector.</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>The restraint minimisation policy provides consistent definitions for restraints and enablers. No residents were restrained or using enablers on the day of the audit at Waratah Retirement Home. All staff receive education regarding restraint minimisation and challenging behaviours. Staff interviewed are aware of the difference between a restraint and an enabler.</p>

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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>All medication files sampled confirmed that they are reviewed as required and discontinued medications are signed and dated by the GP. Allergies are documented, identification photos are present and three monthly reviews are completed. Medication charts are legibly written. The RN was observed administering medication correctly though an improvement is required in using the hand gel sanitizer in between patients and using each medicine cup per resident. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service.</p> <p>Controlled drug book entries were not signed by staff administering or checking medication. Inconsistent use of hand gel sanitizer in between residents during medication administration and only one medicine cup being used for all residents. There were expired medications in the drug room that</p>	<p>The medicines management system is not consistently implemented to manage the safe and appropriate administration, medicine reconciliation and disposal to comply with legislation, protocols and guidelines.</p>	<p>Provide evidence the medication management system complies with current legislation.</p> <p>60 days</p>

		have not been returned to the pharmacy since 2013, 2014 and 2015 respectively.		
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.