# Mission Rest Home Limited - Mission Rest Home

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Mission Rest Home Limited

**Premises audited:** Mission Rest Home

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

**Dates of audit:** Start date: 3 October 2017 End date: 4 October 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:** 21

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

This certification audit was conducted against the Health and Disability Service Standards and the organisation’s contract with the district health board to supply aged related residential services. The Mission Rest Home can provide residential services for up to 23 residents.

The audit process included the review of policies, procedures, resident and staff files, observations and interviews with residents, family, management, a general practitioner and staff.

The organisation has achieved full compliance to this standard. Continuous improvement has been allocated regarding a quality initiative.

## 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. |

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.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents. The staff were noted to be interacting with residents in a respectful manner. Care for residents who identify as Maori is guided by a Māori health plan and related policies.

There was 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 health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The complaints process complies with the Code. Resident feedback is used as an opportunity to improve services.

## 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. |

The rest home is governed by a board of directors. The facility is operated by Mission Rest Home Limited, a charitable trust. The mission and strategic goals are developed and monitored by the directors. The operational management is the responsibility of the general manager. Day to day operations are the responsibility of the facility manager, who is supported by a clinical manager.

A quality and risk management system is in place. The required policies and procedures are documented. Internal quality activities and quality projects are implemented and demonstrate improved outcomes for residents. Adverse events are documented and the corrective action process is providing the organisation with ongoing opportunities to improve quality and safety.

The human resource management and employment practices are in place. There is a system for validating professional qualifications. Staffing levels meet the needs of residents with an experienced registered nurse and care givers available at all times. There is an in-service education programme that covers relevant aspects of support and reflects the needs of the older person.

Resident records are maintained in a confidential manner. Records management meet good practice requirements. All resident records are current and legible.

## Continuum of service delivery

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

Management work closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

The care plans are individualised and based on a comprehensive and integrated range of clinical information. The short term care plans are developed to manage any new problems that might arise. All residents’ files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. The residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by an activities officer and provides residents with a variety of individual and group activities and maintains their links with the community. The community taxi van is accessed for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a hard copy system. Medications are administered by the registered nurses or care staff, 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. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall 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. |

The building complies with legislation. The building is well maintained and fit for purpose. There are adequate supplies and equipment. All equipment and medical devices are routinely checked. There are safe external areas for the residents to enjoy. Each resident has a private room of sufficient size with a shared bathroom or private ensuite. The communal and dining areas are spacious, this includes a large chapel with is utilised by residents, staff, families and the community. Essential emergency and security systems are in place with regular fire drills completed.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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 processes in place to safely manage the use of restraints and enablers in the event they are required. There were no restraints or enablers in use at the time of the audit.

## Infection prevention and control

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| --- | --- | --- |
| 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. |

The infection prevention and control programme aims to prevent and manage infections. The programme is led by the clinical manager (RN) who is experienced and appropriately trained in infection control. Specialist infection prevention and control advice and education is accessed from the district health board. The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and 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 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 91 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Mission Rest Home has policies, procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | All staff interviewed understood the principles and practice of informed consent. The informed consent policies provide relevant guidance to staff. The clinical files reviewed showed that informed consent has been gained appropriately using the organisation’s standard consent form including consent for photographs, outings, invasive procedures and collection of health information.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s file. Staff demonstrated their understanding by being able to explain situations when this may occur.  Staff were observed to gain consent for day to day care on an ongoing basis. |
| 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. Brochures related to the advocacy service were also available in the entrance foyer. The family members and residents spoken with were aware of the advocacy service, how to access this and their right to have support persons. An independent residents advocate lives within the grounds of the facility and visits the service daily, talking to residents, running the residents meetings and helping out. An opportunity to interview the advocate however was not available during the time of audit.  Staff were aware of how to access the resident’s independent advocate and the advocacy service when required. |
| 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 | The residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. The family members interviewed stated they felt welcome when they visit 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 | The complaints policy complies with Right 10 of the Code. Residents and their family are advised on entry to the facility of the complaint processes. The facility manager is responsible for responding to, and managing complaints. There have been two documented complaints for the year 2016 and none for the year 2017 to date. Records were sampled and confirmed that complaints are managed in line with policy and legislative requirements.  A complaints register is documented and complaints are discussed at staff/quality and directors’ meetings. Mandatory staff training includes the management of complaints. There have been no complaints to the Health and Disability Commissioner or the DHB since the last audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The residents and family interviewed report 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 staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The residents and their families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room, with a double room available for a couple. This room was vacant at the time of audit.  Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops, cafes, garden center and areas of interest. Participation in interests of their choosing is encouraged. Each plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records sampled confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | There was one resident in the service at the time of audit that identified as Māori. Interviews, documentation and observation verified Mission Rest Home respects and acknowledges an individual’s culture, values and beliefs and enables this resident to integrate their cultural values and beliefs into their lifestyle. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The residents verified that they are consulted on their individual culture, values and beliefs and that staff respect these. Resident’s personal preferences, required interventions and special needs were included in all care plans sampled, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met, and this supported that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.  The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with a Code of Conduct/House Rules as part of their individual employment contract. It is completed at commencement of employment. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example: district nurses; diabetes nurse specialist; physiotherapist; wound care specialist; community dieticians; services for older people; DHB liaison nurse and education of staff.  The clinical manager (CM) who is a registered nurse (RN) has recently completed a post graduate certificate in advanced clinical assessment and living with long term conditions, supported by the DHB. The CMs knowledge in consultation with specialist advice from the DHB guides the clinical practices at Mission Rest Home, and is based on a philosophy of best practice.  Staff reported they receive management support for ongoing education to support contemporary good practice.  Other examples of good practice observed during the audit included a commitment to ongoing improvement in the care provided. This is evidenced by an ongoing initiative aimed at a reduction in the number of falls, prompt management of acute situations and a commitment to providing a tranquil, peaceful environment that enables residents to see the facility as their home. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The residents and family members stated they were kept informed about any changes to their own or their relative’s 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 sampled and observation of events during audit. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  The CM verified interpreter services can be accessed via the DHB or Interpreting New Zealand when required. Staff reported interpreter services were rarely required due to family members assisting if needed. All current residents are able to speak English. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation is governed by four directors. The strategic plan and budget are set annually. The organisational goals, mission and philosophy are documented and reviewed. The organisational performance is monitored through monthly management reports to the general manager. There is a documented business plan, which is also reviewed annually. One of the director’s lives on the grounds and visits the rest home daily. The operational management is the responsibility of the general manager. The general manager is on site every three months for attendance at directors’ meetings and delegates day to day management of the facility to the facility manager who is on site Monday to Friday, business hours.  The general manager has many years’ experience in managing, owning and operating residential aged care facilities. The facility manager has been in the role since March 2016 and has previously managed a rest home. The facility manager maintains an education log which confirms education hours that exceed those required for managers in the aged care sector, including leadership in aged care training which is provided by the local district health board (DHB).  The facility manager’s position description is documented and includes authorities and responsibilities. The facility manager confirmed that the role is well supported by the general manager and the directors. The facility manager provides the general manager with monthly management reports. Management reports were sampled and include: outputs; occupancy; staff turnover; complaints; policy and procedure review; internal audits; building requirements; facility manager’s goals for the next month; adverse events; infection control and a narrative report by exception. The facility manager’s performance is monitored, with a performance review conducted in 2017.  Mission Rest Home is currently certified to provide 23 rest home level beds and there were 19 residents assessed as requiring rest home level care during this audit. The service provider has contracts with the DHB to provide aged related residential care (rest home), residential respite services and short term services. There were two residents accessing respite services on the day of the audit. There were also six independent residents living / boarding on the first and second floors, and two occupied independent living units in the grounds. These residents/borders receive meals, laundry and housekeeping services provided from the rest home. |
| Standard 1.2.2: Service Management  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. | FA | The facility manager is supported by the general manager and the clinical manager. The rostering policy states that in the planned or unplanned absence of the facility manager, the registered nurse will take to role and responsibility of the day to day management of the rest home. Both the facility manager and the clinical manager share on call services. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is a documented quality management system which covers the scope of the services provided. Relevant standards are identified and included in the policy and procedure manuals. These are accessible to all staff. The policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice and reference legislative requirements. There is a system for reviewing and updating quality related documents with evidence of ongoing reviews in records of meeting minutes sampled. The review and amendment log identifies changes and version numbers. Master copies are maintained by the facility manager. A communication booklet is used to alert staff to changes in the documented system. All policy reviews are approved by the general manager.  A quality and risk management plan is used to guide the quality programme and includes goals and objectives. A range of quality data is gathered and used to monitor and improve services. These include surveys, audits, surveillance activities and staff/quality team meetings.  All quality related data is combined and discussed at monthly quality/staff meetings. This includes: the current status of corrective actions; results of audits; health and safety; infection control; adverse events; restraints; compliments and complaints; privacy and confidentiality; activities; staff recruitment and education.  A quality improvement plan is documented and demonstrates a responsive quality improvement programme. An annual internal audit schedule is documented. There is evidence that audits are completed as required, and used as opportunities for improvement. Opportunities for continual improvement are also documented, implemented and evaluated.  The resident and family satisfaction is monitored. There is evidence that feedback from residents is used to further develop improvement opportunities. Surveys sampled demonstrated overall satisfaction from both relatives and residents. Where required a corrective action is documented.  The resident meetings are conducted every second month. One of the directors is a resident advocate and attends these meetings, as does the facility manager. Resident meeting minutes sampled confirmed open communication, the results of internal audits and corrective actions and discussions regarding upcoming activities.  There is a documented risk management plan which covers the scope of the organisation. The health and safety programme has been amended to reflect current legislation and has been approved by the board. The business plan and hazard register also include organisational risks which are reported to the directors. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is a consistent process for documenting and managing adverse events. The policy and procedures comply with essential notification reporting. Staff are documenting adverse events on an accident/incident form. These are forwarded to the facility manager and the clinical manager for review and closure (depending on type). Corrective action plans are developed as required.  All reports on incidents and accidents are categorised by type and discussed with staff during quality/staff meetings An incident analysis is maintained and a monthly evaluation conducted. Near misses are also reported.  The incident reports sighted confirmed appropriate emergency actions and the required family notifications. Staff confirmed they are made aware of their responsibilities for completion of adverse events. There have been no required essential notifications to external agencies since the last audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | The human resource (HR) processes are documented and meet good employment practice. The HR process is defined and flow chart documented.  The selection and approval of new staff is the responsibility of the facility manager. Professional qualifications are validated during the recruitment process, and annually for nurse practicing certificates. A record of reference checks and police vetting is also maintained. All staff have a signed employment agreement.  All new staff receive an orientation to the organisation and an induction to their perspective duties. This includes the essential components of service delivery and the required competencies. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority.  The facility manager is responsible for the development of the in-service education programme, which includes guest speakers as appropriate. Mandatory education is defined and in-service education is provided via training days that are repeated to make sure all staff attend. All in-service training includes a competency assessment and the content of training sessions is maintained. The required competencies, including medication administration were sighted on all staff records sampled. Both of the registered nurses are trained and competent in the use of interRAI. Training records confirmed that the required topics are provided. There is a system to confirm completion of the required education and competencies for all staff.  Staff performance is monitored as required. An appraisal schedule is in place and current staff appraisals were sighted in staff files sampled. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy and procedure on rostering is documented. The rosters are set based on the layout of the facility and acuity of residents. The facility manager is on site Monday to Friday and the clinical manager is on site Sunday to Thursday. There is another registered nurse onsite the other two days of the week.  There are two care givers on each shift during the day and night. Each shift is filled by staff with a current first aid certificate and medication competency. There is a designated cleaning/laundry staff member who is on site five days per week, and designated kitchen staff.  The care givers interviewed reported that there is enough staff on duty and they were able to get through the work allocated to them. The families interviewed reported there is enough staff on duty to answer the call bells in a timely manner and spend time with them when required.  The rosters sampled confirmed sufficient staff numbers at all times. This included times during staff absence and the provision of an extra care giver rostered to assist in supporting a resident who required additional support. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Each resident has an individual file. The residents’ files include reports from all involved health professionals. The records sampled were tidy, legible, dated and included the designation of the writer. All residents’ records are stored in a secure and private manner. The resident information is not publicly accessible.  Progress notes are documented at the end of each shift by the care givers. Check lists and observation charts are also maintained. All charts and progress notes are reviewed by the registered nurse.  Archived records are securely stored on site. There is a system for retrieving archived records should this be required. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | 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. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager(FM) or the clinical manager (CM). They are also provided with written information about the service and the admission process.  The family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. The files sampled contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.  A dispensation request by Mission Rest Home to the Ministry of Health (MOH) to continue to care for a resident who required an increased level of care, rather than transferring, is no longer required. The resident no longer requires the care services of Mission Rest Home. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Taranaki District Health Board’s (TDHB) ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and coordinated manner. Family of the resident reported being kept well informed during the transfer of their relative. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using a manual/hard copy system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by the RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded.  There were three residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.  Medication errors are reported to the CM or RN and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.  Standing orders are not used. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in March 2017. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures are monitored appropriately and recorded. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile 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. Resident and family interviews voiced a high level of satisfaction in regards to the cook’s willingness to respond to residents requests when residents were unwell or the meal of the day didn’t appeal. Special equipment, to meet resident’s nutritional needs, is available.  Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CM. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of two trained interRAI assessors on site. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans sampled reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans sampled.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. In the letter provided by the GP, there were no concerns in regards to the care provided at Mission Rest Home. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources is available, suited to the level of care provided and in accordance with the residents’ needs. |
| 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. | FA | The activities programme is provided by an activities officer.  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 residents’ activity needs are evaluated regularly and as part of the formal six monthly care plan review.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. The activities reflected residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included: monthly visits by the local pre-school group with residents also visiting the pre-school; visits to and from another rest home; craft sessions; visiting entertainers; quiz sessions and daily news updates. The activities programme is discussed at the minuted residents’ meetings and indicated residents’ input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.  A continuous improvement initiative to enable more resident involvement and interaction has been implemented and evidence verifies this has achieved the desired results (refer 1.2.3.8). |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the CM/RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted where short term care plans were consistently reviewed for infections, pain, delirium, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, CM or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to older persons’ mental health services. Referrals are followed up on a regular basis by the CM or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency with family or in an ambulance if the circumstances dictate, as observed at audit. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are documented policies and procedures for the management of waste and hazardous substances. Personal protective equipment (PPE) is available throughout the facility. Domestic waste disposal meets council requirements and is removed from site as required. Infection control policies include the use of single use items. Chemicals and used products are securely stored or disposed of. All staff receive training on the use of PPE and the management of waste and hazardous substances. Hazardous substances are included in the hazard identification process and a hazardous substances register is maintained. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The facility shares the grounds of a secondary school and is leased off the Diocess. The building has three floors. The ground floor is allocated for the rest home residents only. The second and third floor is occupied by borders that are able to live independently. The other part of the building is used by the school as a hostel, and is completely separate from the rest home. There are also two occupied independent living units in the grounds. There is an enclosed courtyard, separate gardens and plenty of seating outside.  Building compliance is maintained and regular building compliance audits are conducted. There is a current building warrant of fitness. There is a designated maintenance person and maintenance is conducted in an ongoing manner. There is evidence that all maintenance requests are followed up in a timely manner. Hazards are identified and a hazard register is maintained. There is evidence that new hazards are added to the register following audits, incidents or equipment/facility checks. Electrical testing is conducted and medical equipment is calibrated. The boiler is inspected as required.  Furniture is provided and maintained in good order and there is a sufficient amount of supplies and medical equipment is provided. This includes medical devices, wound care and continence products. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are sufficient numbers of toilets, showers and bathing facilities. There is a combination of shared bathrooms, private ensuites and shared facilities. All residents have access to a hand basin in their room or ensuite.  Hot water is maintained at a consistent temperature which is checked monthly. Residents and family members interviewed voiced no concerns regarding the toilet/bathing facilities, including maintaining privacy. Staff and visitor facilities are available. When sharing an ensuite privacy issues are managed per residents needs in discussion with the resident and family. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All resident rooms are single occupancy (with the exception of one double room, which is currently unoccupied). Rooms differ in size and are of sufficient proportions to meet mobility needs and personal items. Each room has a hand basin, cupboard, arm chair and suitable bed to support care needs. Rooms sighted were furnished with a range of personal items. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large, well-furnished lounge and separate dining area. There is an additional activities room, large entry foyer, and a chapel which is well used by the residents and family members. Residents and family members interviewed voiced no concerns regarding the communal and dining areas. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There is a designated staff member who is responsible for cleaning and laundry from Mondays to Fridays. Additional care givers are rostered on the weekend to manage cleaning and laundry requirements. All staff are trained at orientation in the use of equipment and chemicals, with additional chemical safety training provided.  Cleaning and laundry services meet infection control requirements and are of an appropriate standard. There is a large laundry on site which has good separation of clean and dirty areas. There are documented procedures for ensuring flow in the laundry and the transportation and sorting of dirty linen. The cleaning trolley is well stocked and stored securely when not in use. All cleaning chemicals are locked away and labelled.  Cleaning and laundry hazards are documented. Material data safety sheets are displayed. Cleanliness and laundry standards are monitored through annual internal audits and resident feedback. The facility is observed to be clean on the days of the audit. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Appropriate processes are in place to maintain the safety and security of residents over 24 hours and during an emergency. The fire service has approved the current evacuation plan and records of six monthly fire drills were sighted. All external doors are locked at night and staff routinely check all doors and windows each evening. There is outside lighting and a CCTV system inside the building.  The building is separated into fire cells for a staged evacuation. A smoke detectors and sprinkler system is in place and fire extinguishers were sighted. Evacuation procedures are displayed throughout.  Outbreak management and pandemic planning is documented and the required equipment is safely stored. Adequate civil defence supplies are available and include the required equipment and stores. There are adequate food and water supplies in the event of an emergency. There is a generator which will supply heating and lighting in the event of a power failure. The emergency folder (kept in the nurses’ station) includes the management of equipment in the event of an emergency and emergency procedures are documented for a wide variety of situations.  All bed spaces, bathroom and toilets throughout the facility have a nurse call bell and these were seen to be within easy reach of the resident. Sensor mats will also alert in the event the resident has left their bed. The intercom system connects to portable phones carried by staff members. All care givers have a current first aid certificate. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The facility has plenty of natural light. All rooms have a good sized window for ventilation and sunlight. All bedrooms have panel heaters, heated by the boiler. There are electrical heaters in hall ways and a heat pump has been installed in the chapel to help maintain the comfort of the residents. Fan heaters are available in the bathrooms. Interview with residents indicate that the internal environment is maintained at a comfortable temperature. There are no concerns voiced by family regarding the temperature of the facility, however there was one resident who consistently felt cold. Despite numerous medical assessments and interventions the reason for this could not be explained. Staff were noted responding to the needs of this resident by offering warm drinks, finding warm and sunny places for the resident to sit and ensuring appropriate clothing at all times. |
| Standard 3.1: Infection control management  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. | FA | Mission Rest Home 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 comprehensive and current infection control manual, developed at organisational level with input from the CM. The infection control programme and manual are reviewed annually.  The CM is the designated infection control nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the general manager (RN), facility manager and tabled at the quality/staff meetings. Infection control statistics are recorded on a monthly basis and analysed to identify any trends.  Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. There have been no incidents of an outbreak at the facility within the past three years. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control nurse (ICN) has appropriate skills, knowledge and qualifications for the role, and has been in this role for the past three years. The ICN has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available. The ICN has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICN confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  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. | FA | The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and include appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Ongoing IPC education is provided on site by the ICN from the DHB or by the facility’s ICN. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.  Education with residents is generally on a one-to-one basis and has included reminders about hand washing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident’s clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  The ICN/CM reviews all reported infections. 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 quality and staff meetings and at staff handovers. Surveillance data is recorded in hard copy. Graphs are produced that identify trends for the current year, and comparisons against previous years. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures regarding restraints and enablers are consistent with the correct definitions, including the voluntary use of enablers. All staff complete education and competencies regarding restraints, enablers and the management of behaviours of concern. There were no residents using a restraint or enabler at the time of the audit; however in the event a restraint or enabler is assessed as being appropriate, the required assessments, consents, monitoring and review processes are in place. |

# Specific results for criterion where corrective actions are required

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

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

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

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

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | CI | A quality improvement project was commenced in March 2016. This quality initiative commenced following a suggestion for improvement from the activities person, in response to concerns regarding participation in group activities and resident fulfilment in the activities programme. Concerns raised identified that residents were often unable to hear newspaper readings, unable to participle in group conversations and unable to participate fully during resident meetings.  The goal was to improve care delivery to the residents’ daily quality of life by purchasing a portable sound system. Appropriate systems were researched and donations made for purchase. The sound system was trialled in May 2016.  A resident survey was developed to gauge outcomes. The survey results confirmed that 87.5% residents stated they could now hear the newspaper reading which has provided them with enhanced local and world news, 100% of participants reported the sound system enhanced the quality of activities,100% of respondents reported effective communication, 100% stated they were more able to hear information and 83.3% reported that the system has enhanced their enjoyment in daily activities. | An improvement opportunity was identified, planned, implemented and evaluated resulting in improved outcomes for residents. |

End of the report.