Marne Street Hospital Limited - Marne Street Hospital

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 and Disability Auditing New Zealand 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:	Marne Street Hospital Limited
Premises audited:	Marne Street Hospital
Services audited:	Residential disability services - Intellectual; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 19 September 2017 End date: 20 September 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: 53

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

Marne Street Hospital provides hospital (geriatric and medical), rest home and residential disability (intellectual and physical) levels of care for up to 55 residents. There were 53 residents during the audit.

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

The facility manager is appropriately qualified and experienced and is supported by a clinical manager (registered nurse). There are quality systems and processes being implemented. Feedback from residents and families was very positive about the care and the services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

This certification audit identified that an improvement is required in relation to documenting the time of entry in the residents' progress notes.

There is one area of continuous improvement around end-of-life care for residents.

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.		All standards applicable to this service fully attained with some standards exceeded.

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is presented to residents and their families during entry to the service. Policies are implemented to support rights. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Systems are in place to ensure residents, and where appropriate their family or enduring power of attorney, are provided with appropriate information to make informed choices and informed decisions. Residents and family report communication with management and staff is open and transparent. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

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

Services are planned, coordinated, and are appropriate to the needs of the residents. A facility manager and a clinical manager are responsible for the day-to-day operations of the care facility. Quality and risk management processes are implemented. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. The health and safety programme meets current legislative requirements.

Adverse, unplanned and untoward events are documented and investigated. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

Continuum of service delivery

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

The enrolled nurse and registered nurses are responsible for all assessments and the development of the care plans. All resident files reviewed evidenced that assessments and care plans had been completed and evaluated in the required timeframes. InterRAI assessments are completed within 21 days of admission and thereafter at least six-monthly or when there is a change in health condition. Activity assessments and the diversional therapy care plans are completed by the diversional therapist and the activities programme is age appropriate. Special consideration is given to younger people when planning the activities programme. Allied health interventions are documented and integrated into care plans. The service has a contract with a physiotherapist. A podiatrist visits regularly. Marne Street Hospital uses an electronic medication management system that is fully implemented. Food services are provided by an external catering company and resident interviews confirmed satisfaction with food services.

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 has a current building warrant of fitness. A preventative and reactive maintenance plan is implemented. The facility employs a maintenance person who is responsible for day-to-day maintenance and repair. There is a comprehensive check system of the building and equipment that is carried out by the maintenance person. Electrical appliances and medical equipment are tested and tagged by contracted service providers. The facility replaced carpeting in all communal areas with carpet tiles and purchased a carpet cleaning machine to increase use of carpet cleaning. All rooms are personalised and have a mix of private ensuites, shared ensuites and hand basins only. There is adequate room for the safe delivery of hospital level of care within the residents' rooms. Residents can freely access communal areas using mobility aids. Outdoor areas are safe and accessible for the residents. There is adequate equipment for the safe delivery of care. All chemicals are stored safely throughout the facility. The cleaning stuff maintain a tidy and clean environment. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint coordinator is a registered nurse who is responsible for ensuring restraint management processes are followed. On the day of audit there were eleven residents with restraint and seven residents using an enabler.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

Documented policies and procedures are in place for the prevention and control of infections, and reflect current accepted good practice and meet legislative requirements. The infection prevention and control programme is comprehensive and is fully implemented. The enrolled nurse is the infection control coordinator. Staff receive ongoing education related to infection prevention and control. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to staff in a timely manner. The service maintains an outbreak management kit for emergencies.

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	1	48	0	1	0	0	0
Criteria	1	99	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are provided to residents and their families. Policy relating to the Code is implemented. Two managers (one facility manager and one clinical manager), and ten care staff (six caregivers, three registered nurses (RNs), one diversional therapist (DT)) interviewed confirmed their understanding of the Code and provided examples of how the Code is applied to residents' care. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme.
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	Systems are in place to ensure residents, and where appropriate their family or enduring power of attorney (EPOA), are provided with appropriate information to make informed choices and informed decisions. There are informed consent policies/procedures and advanced directives and these were implemented. General consents obtained on admission and consent forms were signed in all eight residents' files reviewed including one YPD contract. Resuscitation plans for residents were appropriately signed. Copies of EPOA were in resident files for residents deemed incompetent to make decisions. Seven out of eight resident files included a completed form of "My Advance Care Plan". The eighth file had included provider specific documentations around advance directives. Residents and relatives interviewed confirmed they have been made aware of and fully understand

		informed consent processes and confirmed that appropriate information had been provided. Staff interviews confirmed information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent. Discussions with family members (including one YPD) identified that the service actively involves them in decisions that affect their relative's lives. Eight admission agreements were sighted and all eight had been signed on the day of admission.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	HDC advocacy brochures are included in the information provided to new residents and their family during their entry to the service. A resident advocate (caregiver) has been appointed. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. Education is provided by the local HDC advocacy service. An HDC advocate attends three to four residents' meetings per year. Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services with evidence of advocacy input for two complaints.
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 service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. In particular, the four residents on the young person with a disability (YPD) contract are provided with one-on-one visits including shopping visits, and attending movies and concerts. Local entertainers regularly visit the facility. A newsletter for residents and family is published every two to three months.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. A reminder about the complaints process is published in the facility's regular newsletter. A register of all complaints received is maintained. Five complaints were received in 2016 and five in 2017 (year-to-date). Documentation, including acknowledgement of each complaint and follow-up letters to the complainant demonstrated that complaints are being managed within HDC guidelines.

		Complaints are linked to the quality and risk management system and to HDC advocacy services. Two complaints have been lodged with HDC (11 May 2015 and 22 November 2016) and are pending review by an independent aged care nurse. Both complaints are related to residents' care. Corrective actions have been implemented to address these complaints. Discussions with residents and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The quality manager/enrolled nurse (EN) discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings. All ten hospital level residents (including one on the young persons with a disability (YPD) contract) and six family interviewed reported that the residents' rights were being upheld by the service.
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' personal belongings are used to decorate their rooms. Privacy locks are on shared and communal toilet doors. The care staff interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All of the residents and families interviewed confirmed that the residents' privacy is respected. Guidelines on abuse and neglect are documented in policy. Staff attend mandatory education and training on abuse and neglect, which begins during their induction to the service. Links are in place with Age Concern for referral if abuse and/or neglect is suspected with examples provided during the audit.
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	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The Māori health plan has been reviewed by a cultural advisor who is linked to Otakau Runaka. There is also a staff member who identifies as Māori. Care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents.

respects and acknowledges their individual and cultural, values and beliefs.		Staff education on cultural awareness begins during their induction to the service and continues as a regular in-service. The caregivers interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service. There were no residents living at the facility who identified as Māori during the audit.
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 service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. It was demonstrated through interviews and observations that staff are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents' care plans, evidenced in all eight care plans reviewed. Residents and family interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	A registered nurse is on-site 24 hours a day, seven days a week. A GP visits the facility twice per week. The service receives support from the district health board (DHB), which includes (but is not limited to) specialist visits (palliative care nurse specialist, gerontology nurse specialist, mental health services and specialists in residential care support (via Waikari Hospital). Support is also provided through Hospice New Zealand. Physiotherapy services are on-site eight hours a week (two days a week) with additional physiotherapy support for ACC injuries and frequent fallers. Residents and family/whānau interviewed reported that they are either satisfied or very satisfied with the services received. The 2016 resident/family satisfaction survey reflect residents and families who are either satisfied or very satisfied with the services being delivered. Results have been shared with staff. The 2017 survey is currently underway. A special project around end-of-life care has resulted in significant and positive outcomes. A nurse

		has been appointed to deal specifically with challenging behaviours. Podiatry visits are six-weekly. A dietitian regularly visits at risk clients. Ear health specialists also regularly visit. A number of quality initiatives have been implemented around pressure injury prevention and management including positioning charts, regular RN checks each shift, staff education both internally and externally via the DHB and detailed instructions for pressure injury equipment. The GP interviewed is satisfied with the care that is being provided by the service.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required. Families interviewed confirmed they are kept informed of the resident`s status, including any events adversely affecting the resident. Twenty accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event. An interpreter service is available and accessible if required. Families and staff are utilised in the first instance. Two residents did not speak English. A translation tool has been developed. Staff and family are used in the first instance. Staff have learned a greeting and simple statements.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Marne Street Hospital is certified to provide care for up to 55 residents at rest home, hospital (geriatric and medical) and residential disability (physical and intellectual) levels of care. Ten rooms are certified for dual-purpose with the remaining 45 rooms hospital only. On the day of the audit, there were 53 hospital-level residents. Four of these residents were on the young persons with a disability (YPD) contract. The facility manager reported that they rarely admit a rest home level resident and would do so under special circumstances only. The facility is owned by three directors who regularly meet with the facility manager. An annual business plan has been developed that includes a mission, vision, values and measurable goals. Staff acknowledged their understanding of the mission, vision and values during their induction to the service, evidenced via their signature. Business goals are regularly reviewed. An experienced facility manager is in charge of operations. She has 26 years of experience in aged care and has been managing this facility since July 2012. She receives support from an experienced clinical manager/registered nurse and a quality manager/enrolled nurse. The facility manager has completed at least eight hours of training related to management of an aged

		care facility, relevant to her role and responsibilities.
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	During the absence of the facility manager, the clinical manager and quality manager are in charge of operations. The clinical manager has 24 years of experience as an RN and has been employed at Marne Street Hospital since October 2012. The quality manager is an enrolled nurse.
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	A quality and risk management programme is in place. Interviews with the facility manager, clinical manager/RN, ten care staff, a quality manager, two kitchen assistants, one cleaner, one maintenance, and one laundry person reflected their understanding of the quality and risk management systems that have been put into place. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures include reference to interRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Quality data collected is collated and analysed. Quality data is regularly communicated to staff via monthly staff meetings. Strategies are implemented to address trends in data (e.g., strategies to address falls in residents' rooms). An internal audit programme is being implemented. Areas of non-compliance include the initiation of a corrective action plan with corrective actions signed off to evidence their implementation. There was evidence in the monthly staff meetings to verify staff are informed of audit results and corrective actions (if any). A quality improvement register is maintained that keeps a running tally of quality initiatives. Examples included (but were not limited to) maximising an effective workforce, data collection and analyses of falls, decreasing the risk of skin accidents, and the provision of palliative care to residents and families (link CI 1.1.8.1). A health and safety programme is in place that meets current legislative requirements. An interview with a health and safety representative (caregiver) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed. The facility has

		achieved tertiary level work safety management practice through ACC (expiry 31 March 2018).
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	An accidents and incidents reporting policy is in place. There was evidence to support actions are undertaken to minimise the number of incidents. Clinical evaluation of residents following an adverse event is conducted by a registered nurse and was evidenced in all 20 accident/incident forms randomly selected for review. Neurological observations were completed when there was a suspected injury to the head. Adverse events are linked to the quality and risk management programme. Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events. The facility manager is aware of the requirement to notify relevant authorities in relation to essential notifications with examples provided. A separate folder contains documented evidence of Section 31 reports that have been completed. Public health authorities were promptly notified following an infectious outbreak (March 2016).
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resource management policies in place which include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity, evidenced in nine staff files randomly selected for review (five caregivers, four registered nurses). Reference checks and police vetting are completed for all new employees. Copies of practising certificates are kept on file. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Evidence of completed induction checklists were sighted in all nine staff files. Annual staff appraisals were up-to-date. An in-service education programme is being implemented meeting contractual requirements. Regular education and training are provided by a range of in-house and external speakers, including but not limited to nurse specialists, Age Concern and the Health and Disability Advocacy Service. In addition to in-service training, informal toolbox talks are in place. Annual competencies are completed for manual handling, emergency management, and carer continuing competency, restraint and medication. Careerforce training for caregivers is underway. Three RNs and one EN have completed their interRAI training.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. The facility manager and clinical manager/RN are on-site Monday – Friday and are available on-call when not on-site. The quality manager is an enrolled nurse and is available Monday – Friday. The facility is staffed with two RNs on the am and pm shifts and one RN on the night shift, seven days a week. There are adequate numbers of caregivers with ten caregivers on the am shift (four staff rostered for eight-hour shifts and six staff rostered for six-hour shifts) and six caregivers on the pm shift (two staff rostered for eight-hour shifts and four staff rostered for six or seven-hour shifts). The night shift is staffed with two caregivers. There have been no changes to staffing since the pay equity changes have been implemented. A pool of casual staff are utilised to cover absences. Activities staff are rostered seven days a week. There are separate domestic staff who are responsible for cleaning and laundry services, seven days a week. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked storage facility located on the premises. Residents' files demonstrate service integration. Entries are legible, dated, and signed by the carer, and include their designation. Missing was evidence of the time of entry, in particular, when an event was documented.
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	FA	The service has comprehensive admission policies and processes in place. Information gathered on admission is retained in residents' records. An information pack is available for residents and families at entry. This includes all relevant aspects of service and residents and/or family are provided with associated information such as the HDC Code of Rights and how to access advocacy. The service conducts an assessment on all new residents. This includes identification of risks. Residents and family members confirm/sign-off that an assessment process is completed and this

identified.		identifies needs and associated risks. Relatives interviewed stated they were well informed upon admission. The admission agreement reviewed aligns with the service's contracts. Eight admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies to describe guidelines for death, discharge, transfer, documentation and follow-up. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Transfer notes and discharge information was available in resident records of those with previous hospital admission. Required follow-up is completed including medication reconciliation and GP follow-up. All appropriate documentation and communication was completed.
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	Medication policies align with accepted guidelines. RNs and the EN are responsible for the administration of medications and all have completed an annual medication competency. The service uses an electronic medication management system and four-weekly blister dose medication packs. RNs complete a medication reconciliation on delivery. There were no expired medications in the trolley or medication cupboards. Sixteen medication charts reviewed identified photo identification and allergy status. The signing sheets in the electronic system demonstrated that medications had been dated and administered as prescribed on the medication chart for all regular and 'as required' medications. Warfarin doses are authorised through the electronic medication system. There are currently two residents self-administering their inhalers only. A competency assessment has been completed with GP authorisation and is reviewed three-monthly. There is evidence of the self-administering being monitored through the electronic medication system. Six out of eight RNs have syringe driver competency. Standing orders were not in use. Two RNs were observed administrating medications safely and correctly. Sixteen medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids	FA	Food services are provided by an external contractor and transported to the facility in hot boxes. The breakfast menu is prepared and served by the staff. All other meals and morning and afternoon tea are provided by the contractor. A stock is kept in the kitchen to accommodate last minute changes in

and nutritional needs are met where this service is a component of service delivery.		food service, and staff are able to make deserts, soups, pasta dishes and sandwiches if required. There is a four-weekly seasonal menu and it was approved by a dietitian in April 2017. The residents' nutritional profiles are kept in a folder in the kitchen, and this information is also provided to the contractor. The folder includes all dietary information and is updated when a new resident enters the service. Information includes any dietary changes and/or weight loss. Food allergies, likes and dislikes are listed in the kitchen. Special diets such as diabetic, vegetarian, pureed, soft, gluten free, lactose free, high protein diets are provided. Meals are plated and served at the main kitchen and the kitchenette next to the second dining room/lounge. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Fridge, freezer and chiller temperatures are taken and recorded daily. Food temperatures are checked on arrival to the facility. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules were maintained. Staff who work in the kitchen have completed or are currently completing their food safety course. The contractor follows a recognised food safety programme. The facility has a food control plan approved by the Dunedin City Council that was dated valid until April 2018. There is specialised crockery such as lip plates and mugs and utensils to promote resident independence with meals. Residents and family members interviewed were very satisfied with the food services and reported that alternative food choices were offered for dislikes.
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	On interview, the facility manager and the clinical manager discussed the process of declined entry and support and alternatives for those declined. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely	FA	All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. InterRAI assessments were completed by the three RNs and one EN who maintain interRAI competency. The service employs eight RNs. Along with the interRAI, other clinical and nursing assessment tools were completed. These include

manner.		but are not limited to; a) pain, b) continence, c) nutrition, d) skin assessment e) pressure injury, f) falls risk assessment, g) mobility, h) wound assessment and i) behaviour assessment. InterRAI initial assessments and assessment summaries were evident in printed format in all files. The information obtained through the assessment processes was reflected into the care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plans reviewed were comprehensive and described the support required to meet the residents' goals and needs. They identified allied health involvement under a comprehensive range of template headings that match interRAI assessments. All resident care plans sampled were resident-centred and included information gathered from assessments, monitoring charts and observations. Residents and their family or EPOA are involved in the care planning and review process. Care plans were amended to reflect changes in health status. There was evidence of service integration with documented input from a range of specialists and allied health providers. These recommendations were included in the care plans and were followed up. Staff interviewed reported they are involved in the care planning process and changes to the care plans are communicated to them through verbal and written handovers. Residents and family members interviewed confirmed they are involved in the care planning process and are happy with the care provided by the service. The 2016 relatives survey results shows 100% satisfaction in overall experience in the facility.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The care being provided is consistent with the needs of residents. This was evidenced through interviews with staff, management team, residents and families. Document reviews also confirmed that care plan interventions reflected the resident's current needs, and appropriately guide staff in care delivery. When a resident's condition and/or care plan interventions change, the RN initiates a GP visit, and when required the clinical manager facilitates a referral to an external specialist. A written record of each resident's progress is documented. Residents' changes in condition are followed-up by an RN as evidenced in residents' progress notes. Family members interviewed stated that they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. There was documented evidence of relative contact for any changes to a resident's health status. RNs described two new roles for caregivers that have been beneficial for the service, one is continence management and the other one is the repositioning, and food and fluid charts. These are added to the caregiver's role. Education relating to these roles are provided to staff.

		Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed, and this could be described by the RNs interviewed. Caregivers and RNs interviewed stated that there is adequate continence and wound care supplies. Wound assessment, wound management and evaluation forms and short-term care plans were in place for 22 wounds. There were three PIs with the remainder of wounds minor skin tears. Monitoring charts sighted included (but were not limited to), vital signs, blood glucose, pain, food and fluid, turning/repositioning charts and behaviour monitoring.
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	An experienced diversional therapist (DT) provides planned activities Monday to Friday. There are two activities coordinators who work on weekends. There is an activities programme calendar, which is displayed in the communal areas. One-on-one time is spent with residents who are unable to or choose not to join in the group activities. Residents were observed participating in one-on-one and groups activities during the audit. The individual activity plan is developed for each resident, and is reviewed at the same time as the care plan in all resident files reviewed. Residents/family have the opportunity to provide feedback on the activity programme through resident meetings, annual surveys and multidisciplinary care reviews. Links with the community was arranged as required, and the DT stated that they invite community groups to the facility as hospital level care residents were not always able to go on outings. There are regular entertainers to the home. Special consideration is given to younger people when planning the activities programme. There were four residents under the age of 65, and an interview with one of these residents confirmed that the programme also meets the individual needs of the younger residents. The YPD resident's file had a range of interventions documented to allow them to participate in a range of cultural, education and leisure activities consistent with their needs and preferences. Volunteers provide one-on-one activities to individual residents under age of 65. Two out of four YPD residents have their own computer. The DT reported that these two residents connect with the world and people externally and their own computer also provides entertainment for them.
Standard 1.3.8: Evaluation Consumers' service delivery plans	FA	Care plans reviewed had been evaluated by an RN or the EN six-monthly or when changes to care occurred. Evaluations were documented and included progress toward meeting goals. There was documented evidence of care plans being updated as required. There is (at a minimum) a three-

are evaluated in a comprehensive and timely manner.		monthly review by the GP. There are short-term care plans to focus on acute and short-term issues, and these are reviewed and signed off when resolved.
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	The clinical manager described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the needs assessment service coordination (NASC), mental health services, nurse practitioner, palliative care specialists, and dietitian and wound care nurse. The service provided examples of where a resident's condition had changed and the resident was reassessed for a higher level of care. Discussion with the clinical manager confirmed that currently one resident was referred to the NASC agency for re-assessment. Internal referrals are completed for the physiotherapist who visits weekly.
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 policies around management of waste and hazardous substances. All chemicals sighted were appropriately stored in locked areas and fully labelled. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Infection control policies state specific tasks and duties for which protective equipment is to be worn. There is an incident reporting system that is in use. The staff orientation process addresses chemical usage, hazard management and the use of material safety datasheets. Personal protective equipment is readily available and staff were observed wearing appropriate protective clothing.
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 building warrant of fitness expires on 7 October 2017. A preventative maintenance plan is implemented. The facility employs a maintenance person who is responsible for day-to-day maintenance and repair, and he also organises external contractors as required. There is a comprehensive check system of the building and equipment to be carried out by the maintenance person. Electrical appliances and medical equipment are tested and tagged by contracted service providers. Hot water temperatures are monitored monthly and required remedies (if any) are addressed in timely manner. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when

		required. The external areas are well maintained and residents can access gardens and indoor areas with ease. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. Resident rooms have carpet or vinyl. The corridors are carpeted and there are hand rails. The facility replaced carpeting in all communal areas with carpet tiles and purchased a carpet cleaning machine to increase use of carpet cleaning. There is a dedicated smoking area and residents are monitored when they smoke.
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	Some rooms have full ensuites, some rooms have shared ensuites and some have hand basins only. Residents, families and caregivers report adequate numbers of toilets and showers in each area. There are numbers of resident communal toilets in close proximity to communal areas. Visitor toilet facilities are available. Residents interviewed stated that their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets were well signed and identifiable.
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	Room sizes differ but are of sufficient size to cater for hospital level residents. There is sufficient space to safely manoeuvre a lifting or standing hoist and for residents to safely move about the room using mobility aids. Residents were observed manoeuvring walking frames in rooms safely and staff were seen to use hoists.
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 are three lounges and dining areas. Residents can choose to have meals in rooms as desired. All communal rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility, one of lounges is used as quiet area. Residents are able to move freely and furniture is arranged to facilitate this. Residents interviewed reported that they can move around the facility and staff assist them if required, and communal areas meet their needs.

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	All laundry is done on-site by designated staff. Chemicals are stored in a locked room in the laundry. A closed chemical dispensing system is used and all chemicals are labelled with manufacturer's labels. Residents and relatives expressed satisfaction with cleaning and laundry services. Effectiveness of cleaning and laundry services are monitored through the internal quality system.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and mandatory education and training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes. A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A gas barbeque is available. A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Call bells are checked regularly by the maintenance staff. There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR 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	General living areas and apartments are appropriately heated and ventilated. Residents have access to natural light in their bedrooms and there is adequate external light in communal areas.
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	FA	The infection control (IC) programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The IC coordinator is an enrolled nurse and she is responsible for infection prevention and control. The IC programme is well established at Marne Street Hospital. The IC committee consists of a cross-section of staff and there is external input as required from the GP, the local DHB and Public Health South. There has been one outbreak since the previous audit (May 2016). All staff are orientated in IC processes on employment and education around IC and prevention is ongoing throughout the year. IC is discussed at every

appropriate to the size and scope of the service.		meeting and during handovers as required.
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	There are adequate resources to implement the IC programme. Infection prevention and control is part of staff orientation. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. IC audits were completed and IC signs were visible throughout the facility. A review of IC programme is completed annually. IC trends from 2013 to date were reviewed and this information is used to set up a facility level benchmark for infection trends. All IC data and other relevant IC information are communicated to staff and visiting health providers.
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 infection control manual outlines a comprehensive range of policies, standards and guidelines, and reflect current accepted practice and meet legislative requirements.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	IC training is facilitated by the IC coordinator. Formal infection control education for staff has occurred and the IC coordinator completed an external IC training. Staff and family interviews confirmed that visitors are advised of any outbreaks of infection in the community or other residential aged care facilities and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in the resident file. This was sighted in two files – a resident with Extended Spectrum Beta Lactamase (ESBL) positive and a resident with Vancomycin Resistant Enterococci (VRE). Staff interviewed were knowledgeable around infection prevention and cross contamination and were given examples of how to provide care to residents with ESBL and VRE. Infection control education was provided in 2016 and 2017 included washing and hand hygiene, waste management, outbreak management and correct use of personal protective equipment. Infection control education

		is also provided at the orientation session for new staff and includes hand hygiene.
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	Infection surveillance is an integral part of the infection control programme and is linked to the quality management programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Results of surveillance are acted upon in a timely manner. Outcomes and actions of IC surveillance programme is discussed at the staff and all other meetings. One outbreak in May 2016 was managed appropriately and effectively. The information obtained through infection surveillance determines infection control activities, resources and education needs within the facility. Internal IC audits also assist the service in evaluating infection control needs. The service maintains a large outbreak management kit, which includes but is not limited to special bins with lids, antibacterial wipes, clothing protectors, gowns, surgical masks, N95 masks, gloves, specific bags for contaminated items, antibacterial gels and sprays. There is also a stock of bleach based cleaning products. Staff are encouraged to take the flu vaccine and this was facilitated by the service. In 2017, staff flu vaccine intake was 48.4 %.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers. Eleven residents were using restraints and seven residents were using bedsides as an enabler. One file for enabler use (bedsides) was selected for review. An assessment was completed and written consent was provided by the resident. The enabler was being reviewed three-monthly. The care plan included sufficient detail around the resident's use of the enabler. Staff interviews confirmed their understanding of the differences between a restraint and an enabler. Staff receive regular training around restraint minimisation that begins during their induction to the service. A restraint competency questionnaire is completed by staff each year.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of	FA	The restraint coordinator is an RN. She is supported by an (additional) designated restraint caregiver. Restraint minimisation policies and procedures describe approved restraints. Restraint use is discussed in the monthly RN/quality/restraint meetings and in caregiver staff meetings.

restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The restraint coordinator is responsible for assessing a resident's need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. Assessment tools are in place for restraint use. Four residents' files where restraint was being used were randomly selected for review. Each resident using restraint had a restraint assessment completed. Family had signed informed consent for restraint use. The restraint assessment addressed risks associated with restraint use.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	A restraint register is being implemented. The register identifies the residents that are using a restraint or an enabler. Eleven residents were listed on the restraint register. The types of restraints used were bedsides (eleven) and lap belts (four). Lap belts are used to keep residents safe while using mobility equipment. The four restraint assessments reviewed identified that restraint is being used only as a last resort. The restraint assessment process includes determining the frequency of monitoring while restraint is in use. Restraint use was linked to the residents' care plans. Restraint policy indicates that all residents are monitored two hourly at a minimum. Care staff are kept informed regarding restraint procedures and documentation requirements and take responsibility to ensure restraint monitoring is correctly documented. Monitoring forms for the files reviewed were completed accurately and included when the restraint was put on and when it was taken off.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint evaluations take place three-monthly, evidenced in all four residents' with restraint files reviewed. Restraint use is discussed in monthly RN/quality/restraint meetings and in caregiver staff meetings. This was confirmed in the meeting minutes.
Standard 2.2.5: Restraint Monitoring	FA	The restraint minimisation programme is reviewed annually. The review included identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff

and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.		education and restraint competency assessments.

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)
Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.	PA Low	Progress notes do not routinely include the time of entry, in particular, when an event has occurred.	The majority of progress notes reviewed were missing the time of entry, stating ‘am’ or ‘pm’ instead. This was of particular concern when there was evidence of an event occurring (e.g., pain assessment, adverse event, positioning).	Ensure that progress notes include the time of entry. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	A special project around providing palliative care to residents and families was initiated in 2016 with positive results.	On 29 November 2016 a project was implemented around providing end-of-life care to residents and families. The goals of the project were to: 1) Reduce the number of transfers so that residents could be cared for during their end-of-life at the facility. 2) Increase the skill level and confidence of staff in caring for residents who were dying. 3) Improve the level of networking and collaboration with the palliative care clinical nurse through Otago Hospice. 4) Promote advanced care planning for all residents. Outcomes from this project include the following: 1) Only one resident was transferred for end-of-life care after the project commenced. 2) A clinical nurse specialist (CNS) service through Otago Hospice was selected to join in on this project. Education of staff was a key initiative. 3) At the conclusion of the project, fifteen of twenty staff who returned their survey (nine RNs, and six caregivers) which reported: that they either agreed or strongly agreed that the objectives of the palliative care and CNS objectives were being met and that their confidence had improved, which supported enhanced care of the dying. 4) All residents at Marne Street Hospital now have an advanced care plan in place.

End of the report.