# Masonic Care Limited - Edale Aged Care

## Introduction

This report records the results of a Provisional 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](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:** Masonic Care Limited

**Premises audited:** Edale Aged Care

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 6 April 2018 End date: 6 April 2018

**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:** 22

# 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.

## General overview of the audit

The Edale Trust board governs Marton Edale home. Marton Edale Home is currently certified to provide rest home and hospital level care for up to 30 residents. On the day of audit, there were 22 rest home residents. The service has not yet commenced hospital level of care.

This provisional audit was completed to assess the suitability and preparedness of the prospective merge between two charitable trusts. The provisional audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family member, general practitioner, staff and management.

The facility manager (non-clinical) has been in the role for one year. She is supported by a clinical manager who has been in the role since July 2017 and a service delivery manager who has been in the role since January 2017.

The service has an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

The prospective charitable trust board have been operating aged care facilities for over 45 years and led by experienced trust board chief executive officer and board members.

This provisional audit has identified areas requiring improvement around; education, first aid training, recruitment of staff for hospital level care, medicine management and specialist equipment.

## Consumer rights

Marton Edale trust provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

## Organisational management

The quality and risk management plan and quality and risk policies describe Marton Edale’s quality improvement processes. Policies and procedures are maintained by an external aged care consultant who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, internal audits and surveys. Quality data is discussed at meetings and is documented in minutes. Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements. There are human resources policies including recruitment, job descriptions, selection and orientation that provides new staff with relevant information for safe work practice. There is a 2018 education plan in place. The staffing policy aligns with contractual requirements for rest home level of care.

## Continuum of service delivery

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior health care assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals and baking provided.

## Safe and appropriate environment

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are no ensuites but there are sufficient communal showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

## Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler or restraint, should this be required. The clinical manager is the restraint coordinator. Staff complete competency questionnaires on restraint minimisation. There were no restraints in use and one enabler. Voluntary consent had been obtained.

## Infection prevention and control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical manager is the infection control coordinator who is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 40 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 87 | 0 | 3 | 3 | 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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. A policy relating to the Code is implemented and care staff interviewed (one nurse manager, one registered nurse (RN), two healthcare assistants and one diversional therapist) could describe how the Code is incorporated into their everyday delivery of care. The proposed merger is between Marton Edale Trust and The Masonic Villages Trust, with Masonic Care Ltd, a registered charitable company assuming the service contracts with the Wanganui DHB. The Board members of Masonic Care Limited (MCL) are experienced and knowledgeable in the delivery of consumers rights under the Code with MCL operating four other care facilities in Hutt Valley, Wairarapa, Horowhenua and Manawatu regions.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has in place a policy for informed consent. Completed resuscitation consent forms were evident on all resident files reviewed (six rest home, including one intermediate care). General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney evidence is filed in the residents’ charts. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Health and disability advocacy information is included in the information provided to new residents and their family/whānau during their entry to the service. Brochures and contact numbers are available to residents and family. Residents interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. Staff receive education on the role of advocacy services during their induction to the service. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | The service encourages their residents to maintain their relationships with friends and community groups. Families are encouraged to visit. Residents may have visitors of their choice at any time. Residents are encouraged to maintain community links such as attending church services and community events. Volunteers are involved in the service and there are strong community links. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | There is a complaints policy to guide practice which aligns with Right 10 of the Code. The privacy officer (clinical manager) would lead the investigation of any concerns/complaints in consultation with the facility manger. Complaints forms are visible at the main entrance to the facility. There have been no complaints made since the last audit. Residents and families interviewed are aware of the complaints process. There have been no complaints registered for 2018 to date.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers 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 clinical manager 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. Nine residents and one relative interviewed reported that their rights were being upheld by the service.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | During a tour of the facility it was evident that the residents’ privacy and dignity was maintained. Two healthcare assistants (HCAs) and one registered nurse (RN) interviewed, reported that they knock on bedroom doors prior to entering rooms. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and the one family member interviewed during the audit confirmed that the residents’ privacy is respected. Guidelines on abuse and neglect are documented in policy. The residents’ personal belongings are used to decorate their rooms as viewed on the day of audit.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 | 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. There is a Māori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The policy includes references to other Māori providers that are available and interpreter services. There is a Māori health plan in place for two residents who identified as Māori on the day of audit. Both Māori health plans acknowledged the cornerstones of Māori health and the importance of whānau involvement in the care of the resident. One Māori resident (interviewed) confirmed their cultural values and beliefs were recognised and respected by all staff.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service identifies the residents’ personal needs, culture, values and beliefs at the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. Beliefs and values are incorporated into the residents’ care plans in resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. There was documented evidence of the service acknowledging other cultures around values, beliefs, religion and food.  |
| Standard 1.1.7: DiscriminationConsumers 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 individual employment agreement and job descriptions. Interviews with the staff confirmed their understanding of professional boundaries including the boundaries of their role and responsibilities. Staff sign a confidentiality clause and security policy (including use of CCTV) on employment.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Good practice was evident. A registered nurse is available on morning duty seven days a week and afternoons three days a week. There is an RN after-hours to provide support and advice to staff. The service identifies areas for improvement from feedback received on the service through resident/family and staff meetings. Residents and family/whānau interviewed reported that they are very satisfied with the services received. The service participated in a pilot programme SEQUAL with hospice, around providing palliative care for all end of life conditions. Education and liaison with hospice has been ongoing.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Management promotes an open-door policy. The relative and residents confirmed they are aware of the open-door policy stated that staff and management are approachable and available. Residents have the opportunity to feedback on service delivery through resident meetings and surveys. Survey outcomes from November 2017 have been communicated to residents and suggestions have been implemented including a recent barbeque and outings to museums. Incident reports reviewed recorded family notification. One relative interviewed, confirmed they are notified of any changes in their family member’s health status. The facility has an interpreter policy to guide staff in accessing interpreter services.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Marton Edale Home is currently certified to provide rest home and hospital level care for up to 30 residents. On the day of audit there were 21 residents under the ARCC and one resident under an intermediate care contract. There are nine dual-purpose beds. The service has yet to commence hospital level care of care. The Edale Trust board is made up of 11 community volunteers including representation from churches, service and voluntary agencies. There is a 2016 – 2021 Edale Trust Board strategic plan that includes the Edale vision and values, key objectives, accountability and timeframes for goals relating to governance, employment, service delivery and property development. Management and the board have reviewed the 2017 business plan. The board receive monthly reports from the facility manager, clinical manager and services delivery manager. The facility manager attends board meetings. The facility manager (non-clinical) has been in the role for one year. She is supported by a clinical manager who has been in the role since July 2017 and a service delivery manager who has been in the role since January 2017. The three managers are supported to attend external training and have completed at least eight hours of professional development relating to managing an aged care facility, including attending an aged care study day on managing complaints, workforce, leadership and critical thinking. The clinical manager has completed a DHB clinical study day, fundamentals of palliative care, interRAI training and syringe driver competency. The prospective charitable company, Masonic Care Limited (MCL), has signed a memorandum of understanding with the Marton Edale Trust outlining the intent of the trust to merge. The DHB has been informed and the chief executive officer of MCL has met with the portfolio manager of the DHB. The CEO is on the board of an the New Zealand Aged Care Association. Financial reporting has been prepared and overseen by MCL since September 2017. The board of MCL has a board of six directors (two external directors and four from the main Trust Board). MCL operates four other rest home and hospital facilities and there will be additional senior nursing support and mentoring for the management team provided from a nearby MCL facility. The CEO visits sites regularly in a regional manager role. The trust has a quality leader based at one of their facilities nearby, who oversees the quality systems, including the review of policies and procedures. The Masonic Care Ltd have an overarching business plan across the facilities that will be adopted by Marton Edale. Each facility then generates its own quality initiatives focused on resident outcomes. The facility manager and service delivery manager were initially on fixed term contracts and appointed permanent positions in September 2017.The tentative merger date is immediately post HealthCERT approval. Relevant authorities have been notified of pending change of ownership. |
| 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 prospective charitable company, MCL chief executive officer and current management, informed that there will be no changes in the day-to-day operation of the facility. The prospective charitable company MCL is based in Wellington and available to management as required. The facility manager (non-clinical) and clinical manager are available on call after hours. The administration officer covers the facility manager absence and a RN will cover the clinical manager absence. With the new merger of Trusts there will be senior nursing and management support available from a nearby MCL facility in Palmerston North.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service has a quality risk management plan in place that has been reviewed. An external consultant has developed a range of policies to support service delivery and they are reviewed regularly by the service. Lippincott policies are accessible to staff on-line. Policies reviewed are relevant to the provision of rest home and hospital level care. Discussion occurs at management and general staff meetings around quality data including compliments, health and safety, accident/incident, infection control, internal audit and survey results. Trends are identified and analysed for areas of improvement. Clinical RN meetings have commenced with the appointment of RNs. Meeting minutes and quality data is available for staff, as sighted on the staff room noticeboard. Annual resident/relative satisfaction surveys are completed, with results communicated to residents/relatives and staff. Internal audits are completed and include environmental, infection control, organisational and clinical audits including medication audits. Corrective actions are implemented for any audits that are not compliant. The health and safety coordinator is the service delivery manager, who has completed health and safety level three training. The health and safety committee are representatives from across the services and meet bi-monthly to review accidents/incidents and hazards. There is a health and safety noticeboard in the staff room with meeting minutes and work safe newsletters displayed for staff. Health and safety is included in the orientation programme and staff complete a competency questionnaire. The hazard register is current. Contractors on-site have all completed health and safety inductions. Falls prevention strategies are in place that includes the analysis of falls (location and time) and the identification of interventions on a case-by-case basis to minimise future falls. Interview with the prospective charitable company MCL chief executive officer confirmed they have a robust quality and risk management system overseen by a quality leader who covers all MCL facilities. The quality leader will review Edale policies and procedures as they fall due and integrate them into the MCL document control system. |
| 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 an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted, including any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme. Nine accident/incident forms were reviewed. Each incident involving a resident had clinical assessment and follow-up by a registered nurse. Neurologic observations were conducted for unwitnessed falls. The facility manager reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. There have been no reportable events since the surveillance 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.  | PA Low | There are human resources policies to support recruitment practices. Six staff files (one clinical manager, one registered nurse, one service delivery manager, two HCAs and one activities coordinator) contained all relevant employment documentation. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and suitability for the role. Performance appraisals are completed at 90 days and annually thereafter. Current practising certificates were sighted for the clinical manager, RNs and general practitioners. An orientation programme provides new staff with relevant information for safe work practice. Healthcare assistants interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. The in-service training calendar did not provide annual and two yearly mandatory training requirements (link 1.3.12.3 and 3.4) for 2017. The training plan has commenced for 2018 and is provided in conjunction with the monthly staff meetings. The service delivery manager, also a qualified HCA with level four unit standards is in the process of completing Careerforce assessor training.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Low | The human resources policy determines staffing levels and skill mixes for safe service delivery. The facility manager, clinical manager and the service delivery manager are on duty during the day from Monday to Friday. The clinical manager and RN provide the on-call requirement for clinical concerns. Staff, residents and relatives state there were adequate staff on duty at all times. Staff state they feel supported by management who respond quickly to afterhours calls. Marton Edale Home currently provides rest home care for up to 30 residents. Nine of the thirty beds were dual-purpose for rest home or hospital level, but this area has yet to opened for hospital level care. There is one RN on duty on the morning shift Wednesday to Sunday, and one RN on duty on the afternoon shift, Monday to Wednesday. The RNs are supported by two HCAs on duty on the morning and on the afternoon shifts, and two HCAs on duty on the night shift. A draft roster provides 24-hour RN nursing cover and adequate HCA hours for hospital level of care. The service is continuing to recruit RNs and HCAs to provide 24-hour cover for hospital level of care. An experienced RN with interRAI training had been appointed to commence within the next week. The prospective MCL chief executive officer interviewed stated there will be no changes to staff and the existing rosters will remain.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident’s individual record. 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. Residents’ files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant HCA or RN, including designation.  |
| 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 | There are policies and procedures to safely guide service provision and entry to services, including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. All five admission agreements for permanent residents (sighted) were signed and dated.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. Intermediate care residents have their discharge recorded in the progress notes. |
| 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. | PA Moderate | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are standing orders in use, however, these do not meet the prescribing requirements. The facility uses an electronic and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent HCAs administer medications. Some staff do not have up-to-date medication competencies and there has been no medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked weekly. Eye drops are dated once opened. Staff sign for the administration of medications electronically. Twelve medication charts were reviewed (including one intermediate care). Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. ‘As required’ medications had indications for use charted. Controlled drug register weekly checks have not always been completed.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The service has two cooks and three kitchenhands who cover Monday to Sunday from 6.00 am to 6.30 pm. All but the new cook who is still being orientated, have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served directly from the kitchen to the dining room. Meals going to rooms on trays, have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit, meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The four-weekly menu cycle is approved by a dietitian. The cooks freeze curries for the Indian resident, therefore these are available as desired. Both Māori residents have been offered ‘boil ups’ and these have been declined. All residents and the one family member interviewed, were satisfied with the meals. The food control plan is being submitted under the MCL trust board.  |
| 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 | The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The interRAI assessment tool is implemented. InterRAI assessments had been completed for all long-term residents whose files were sampled. Care plans sampled were developed on the basis of these assessments. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident-centred. Interventions documented support needs and provide detail to guide care. The service has made a number of improvements to care plans since their previous certification audit. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident’s condition changes the registered nurse initiates a GP consultation. Staff state that they notify family members about any changes in their relative’s health status. All care plans sampled had interventions documented to meet the needs of the resident. The service has made a number of improvements to care plans since their previous certification audit. Care plans have been updated as residents’ needs changed. Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies.Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently six wounds being treated. One chronic wound has had input from the GP and wound care nurse specialist.Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is one diversional therapist who works 33 hours a week Monday to Friday. On the days of audit residents were observed playing bowls, cards and scrabble and watching the Commonwealth games on TV. There is a weekly programme in large print on noticeboards and residents also have a copy in their rooms. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents’ needs. These include exercises, games, quizzes, music brain teasers, and walks outside.Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need, and to have a chat.There are monthly interdenominational church services held in the facility and Catholic church members come to give communion. There are van outings at least three weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers’ Day, Anzac Day and the Melbourne Cup are celebrated. The facility has one cat and a pet therapy team visit three weekly.There is community input from the library, pre-schools and schools and Plunket mothers and babies who visit fortnightly. The latter brings great joy to the residents.Residents have an activity assessment completed over the first few weeks following admission that describes the residents’ past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held three monthly.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The five long-term care plans reviewed of permanent residents had been evaluated by the registered nurses six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the long-term residents, and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. The family member interviewed confirmed that they are informed of any changes to the care plan.  |
| 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 | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist and mental health services for older people. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. |
| 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 regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building holds a current warrant of fitness which expires 17 July 2018. There is a maintenance person on-site for 20 hours a week. Contractors are used when required.Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents’ rooms are carpeted, and communal showers and toilets have nonslip vinyl flooring. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. Healthcare assistants interviewed stated they have adequate equipment to safely deliver cares for rest home level of care residents.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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 no ensuites, but each room has a hand basin. All rooms share communal showers and toilets. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and in larger ones, a hoist if appropriate. There are privacy signs on all shower/toilet doors. |
| 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’s rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. The nine dual-purpose rooms are spacious enough to manoeuvre a hoist for transfers. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. One lounge opens out onto an attractive courtyard. There is a spacious dining room off the kitchen.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is done on-site by the cleaner after the cleaning is completed. The laundry is divided into a ‘dirty’ and ‘clean’ area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. All chemicals on the cleaner’s trolley were labelled. There is a sluice room for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept closed when not in use.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate | There are policies and procedures on emergency and security situations, including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. In December 2016, the service conducted an earthquake exercise in partnership with the Whanganui Civil Defence unit. Civil defence supplies are readily available within the facility and include water, food and supplies (torches, radio and batteries), emergency power and barbeque. A generator is readily available on standby through a local company. There is an approved fire evacuation scheme in place dated 3 July 2009. There are six monthly fire drills. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction, and is ongoing. Not all shifts have a current first aider on duty. Residents’ rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated, light up on corridor lights that are visible from all areas in the facility. Security policies and procedures are documented and implemented by staff. The buildings are secure at night with afterhour’s doorbell access, which is connected to the call bell system.  |
| 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 | All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. There is an outdoor area where residents smoke. All other areas are smoke free.  |
| Standard 3.1: Infection control managementThere 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 | The clinical manager has responsibility for infection control across the facility. A registered nurse is currently being mentored into the role. Responsibility for infection control is described in the job description. The infection control coordinator oversees infection control for the facility and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually.Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control coordinator has been in the role since July 2017 and yet to complete specific infection control education, however, has attended an external DHB study day that covered wounds and pressure injury prevention. There is access to infection control expertise within the DHB, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics. An infection control committee has been recently established to meet monthly, comprising of the infection control coordinator, service delivery manager, RNs and HCA.  |
| Standard 3.3: Policies and proceduresDocumented 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 policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by an infection control specialist.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme (link 1.2.7.5). Staff have completed hand hygiene audits and infection control questionnaires. Resident education occurs as part of providing daily cares and as applicable at resident meetings. During the summer weather a resident education session was held around fluids and hydration. The resident education session was recorded as sighted.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends, is discussed at staff and clinical RN meetings. Meeting minutes including graphs are available to staff. Trends are identified, analysed and preventative measures put in place. A monthly report is forwarded to the trust board meeting. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There are current policies and procedures around restraints and enablers. The clinical manager is the restraint coordinator. There was one resident using an enabler (bed loop) on the day of audit. The resident had given voluntary verbal consent as identified on the consent form. The use of enabler was identified in the long-term care plan and reviewed as part of the care plan review. There were no restraints in use on the day of audit. Staff receive training around restraint minimisation and complete restraint competency questionnaires.  |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The monthly education plan for 2017 had four education sessions completed for pressure injury prevention, manual handling, hospice and communication. The monthly education sessions have commenced for 2018. Not all mandatory education has been completed. Staff interviewed confirmed these are held in conjunction with the staff monthly meetings. Registered nurses have access to external DHB study days and the DHB on-line learning modules.  | Education for medication management and infection control has not been completed annually. Other two-yearly mandatory education has not been completed within the last two years including (for example) nutrition, pain management, continence management and the ageing process. There are insufficient staff with first aid training to cover all shifts (link 1.4.7.1).  | Ensure all education and training requirements are offered and completed within the required timeframes. 90 days |
| Criterion 1.2.8.1There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Low | A draft roster for adding hospital level identifies 24-hour RN cover and adequate HCA hours. The service has not yet recruited additional RNs and HCAs to cover the draft roster and provide 24-hour RN cover. | Registered nurses and HCAs have not yet been recruited to provide 24-hour cover for hospital level of care. | Ensure there is a RN on duty at all times prior to the admission of hospital level residents.Prior to occupancy days |
| Criterion 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Medications are prescribed electronically. Pharmacy delivers the medications and checks them in with a RN. The standing orders are reviewed annually but do not meet the standing order guidelines. The pharmacy completes six monthly checks of medications. All medications are stored safely. All medications that are no longer required are returned to pharmacy for disposal. Controlled drugs are signed out by two care staff, one of whom is medication competent (link 1.3.12.3).  | (i) There have been no controlled drug register weekly checks completed since October 2017.(ii) Standing orders do not have the contraindications of each medication documented. | (i) Ensure controlled drug register checks are completed weekly.(ii) Ensure standing orders have contraindications documented.60 days |
| Criterion 1.3.12.3Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Registered nurses administer the medications on morning shifts and HCAs on afternoons and night shift, however, not all HCAs have completed a medication competency and medication education. | (i) Five out of five HCAs and one service delivery manager have not completed medication competencies.(ii) There has been no medication education in the last year. | (i) Ensure all staff administering medications have current medication competencies.(ii) Ensure medication education is completed annually.60 days |
| Criterion 1.4.2.1All buildings, plant, and equipment comply with legislation. | PA Low | All current buildings, plant and equipment comply with legislation. The facility has dual-purpose beds but currently only provides rest home level care. There is a sling hoist but no specialised shower equipment for hospital level of care residents. | Specialised shower equipment has yet to be purchased. | Ensure specialised shower equipment is purchased prior to admission of hospital level of care residents. Prior to occupancy days |
| Criterion 1.4.7.1Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Moderate | Health and safety training in emergencies include fire drills, civil defence and competency questionnaires. The registered nurses have current first aid certificates, however, there is no 24-hour RN cover, leaving some shifts uncovered with a staff member trained in first aid/CPR.  | There is no staff member trained in first aid/CPR on the weekend morning shifts and no night staff have current first aid certificates.  | Ensure there is at least one staff member trained in first aid/CPR on each shift 24 hours. 60 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.

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End of the report.