# Mitchell Court (Tauranga) Limited - Mitchell Court

## 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](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:** Mitchell Court (Tauranga) Limited

**Premises audited:** Mitchell Court

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

**Dates of audit:** Start date: 19 March 2018 End date: 20 March 2018

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 30

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

Mitchell Court provides rest home level care for up to 35 residents. On the day of the audit there were 30 residents including four independent boarders.

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, and interviews with residents, relatives, management, staff and the general practitioner.

The owner/directors are supported by a facility manager/registered nurse and a nurse manager and stable workforce. Residents and family interviewed were complimentary of the service they receive.

There were no areas identified for improvement at this certification audit.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Management and staff 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

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The quality and risk management plan and quality and risk policies describe the quality improvement processes. Policies and procedures are maintained by a group of directors and managers of four local facilities known as the Cavell Group. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys and benchmarked within the group. 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, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and on-line and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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. |

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The care plans are resident, and goal orientated. Input from the resident/family is evident in the service delivery. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a three-monthly general practitioner review. Residents and family interviewed confirmed that they were happy with the care provided and the communication.

Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals cooked on-site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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. |

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness. All resident rooms are single occupancy, and several have their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is an adequate number of shower and toilet facilities for the number of residents. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. There is a staff member on duty at all times with a current first aid certificate.

## 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 to guide staff in the use of an approved enabler and/or restraint, should this be required. Staff receive regular education and training on restraint minimisation. No restraint or enabler was in use on the day of audit.

## 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. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The nurse manager has overall responsibility for infection control education and collation of events for surveillance. 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.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The 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 staff interviewed (one registered nurse/facility manager, one nurse manager, three health care assistants and one activities coordinator) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the 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 | An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The health care assistants interviewed, demonstrated a good understanding in relation to informed consent and informed consent processes.  Family and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.  A multipurpose informed consent form is utilised by the service provider and is retained in each individual resident`s record. Forms are signed and dated appropriately. All resident’s files sampled had signed admission agreements on file.  The GP interviewed, understood the obligations and legislative requirement to ensure competency of residents as required for advance directives and advance care planning. Resident reviews were undertaken six monthly. Reviews of the individual residents’ health status was documented and retained in each personal file reviewed. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Health and Disability advocacy brochures are included in the information provided to new residents and their family/whānau during their entry to the service. Advocacy services and contact numbers are available at the main entrance of the facility. 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. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. |
| 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 encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. 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. |
| 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 (facility manager) leads the investigation of any concerns/complaints in consultation with the nurse manager for clinical concerns/complaints. Concerns/complaints are discussed at the monthly management and staff meeting as sighted in the meeting minutes. Complaints forms are visible at the man entrance. There have been three complaints made in the year 2017 and nil to date for 2018. Appropriate action has been taken within the required timeframes and to the satisfaction of the complainants. Residents and families interviewed are aware of the complaints process. A complaints register is maintained. |
| 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 manager or nurse manager discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident meetings. Seven residents and three family members 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. Three caregivers interviewed reported that they knock on bedroom doors prior to entering rooms (this was observed during audit). Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents’ privacy is respected. Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | 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 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. The service has access to a local cultural advisor and Kaumātua from the local Marae. A Māori health plan is developed where residents identify as Māori. The management group hold quarterly Māori health meetings to discuss the needs/supports for Māori residents. There were two Māori residents on the day of audit. However, they did not specifically identify with Māori culture. There is a Māori staff member available to support residents and staff as required. Staff education on cultural awareness begins during their induction to the service and as part of the two-yearly training programme last provided February 2018. |
| 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, 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. |
| 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. | FA | Good practice was evident. A registered nurse is available during the day shift and on-call 24 hours a day, seven days a week. A general practitioner (GP) visits the facility fortnightly or more often if required. Resident/family meetings are held. Policies and procedures are developed by a group of directors/managers (Cavell Group) that reflect best practice and used to guide staff in the safe delivery of care. Residents and family/whānau interviewed, reported that they are very satisfied with the services received. A resident/family satisfaction survey is completed annually and confirmed high levels of satisfaction with the services received. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Residents interviewed confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. Ten incident forms reviewed for February 2018 identified family were notified following a resident incident. The facility manager and nurse manager confirm family are kept informed. Family members interviewed confirm they are notified promptly of any incidents/accidents and are kept informed on resident health concerns. Interpreter services are provided as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Mitchell Court provides care for up to 35 rest home level residents. On the day of audit there were 26 rest home level residents under the ARCC and four independent boarders. The independent boarders receive no services. There were no respite care residents or younger persons.  The service is part of the Cavell Group of four local rest homes who are also members of an aged care association. The Cavell group has an overall business strategic plan that includes the mission and philosophy of care. Each service has its specific quality plan that is reviewed annually. Mitchell Court has implemented full day training programmes and has continued to upgrade and refurbish the facility.  The facility has been privately owned by two directors (non-clinical) for seven years. The main owner/director visits and meets at least fortnightly with the management team (facility manager, nurse manager and head chef/health/safety representative). There is an annual Cavell Group director’s meeting and the group also holds quarterly managers and clinical managers meetings.  The facility manager has been in the role almost a year and is a registered nurse (current annual practicing certificate sighted), with previous experience in management and regional roles within the health sector, including past ownership of a rest home for five years. He has attended at least eight hours of professional development within the last year relating to managing a rest home including an aged care leadership course, food control plan education with MPI (ministry primary industries) and provider meetings.  The nurse manager has been in the role since June 2016 and has previously been working in aged care. She has completed interRAI training, first aid, wound care and advance care planning including all on-site in-service. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The facility manager and nurse manager cover for each other’s leave and share the on-call requirement. |
| 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 | The Cavell Group quality and risk management plan and quality and risk policies describe the groups improvement processes. Mitchell Court access the Cavell Group policies and procedures through the website and there are paper-based copies available for all staff. Polices are reviewed by the group at least two yearly to ensure they align with current good practice and meet legislative requirements. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. Data is collected is analysed and compared monthly, six monthly and annually for a range of adverse event data (for example skin tears, bruising, falls, pressure injuries). Corrective actions are documented, implemented where improvements are identified and are regularly evaluated. Information is shared with all staff as confirmed in meeting minutes, sighted on noticeboards and during staff interviews. The service is benchmarked within the Cavell Group of facilities.  There are monthly staff meetings held. Staff interviewed confirmed quality data is discussed at the meeting including infections, accidents and incidents, health and safety, concerns/complaints, internal audit outcomes and quality goals. Meeting minutes and graphs were sighted on the noticeboard. There is an internal audit programme that covers environmental and clinical areas. Corrective actions have been generated and completed for any areas of no-compliance.  Resident/relative general satisfaction surveys of all services have been completed last in November 2017. Collated returns were all positive. The activity survey has been completed three monthly and resident suggestions have been implemented such as increasing entertainment from fortnightly to weekly.  A 2017-2018 risk management plan is in place. Staff receive health and safety training, which is initiated during their induction to the service and competed annually during their compulsory training day. All staff are involved in health and safety, which is a topic in the monthly quality/staff meetings. The head chef is the health and safety representative and attends the managers meeting and staff meeting. Actual and potential risks are documented on the current hazard register.  Falls management strategies include sensor mats, and the development of specific falls management plan to meet the needs of each resident who is at risk of falling. Individual graphs for fallers identify time and location of falls to assist staff and management in the prevention of falls. |
| 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. Ten accident/incident forms were reviewed. Each incident recorded timely assessment and follow-up by the registered nurse. The owner/director and facility manager reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. HealthCert had been notified of change of facility manager and nurse manager.  The DHB had been notified regarding an incident that required re-assessment of level of care. Police had been involved in a missing person who was a boarder and not a resident under the ARCC. |
| 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 resources policies to support recruitment practices. Seven staff files reviewed (facility manager, nurse manager, three HCAs, one head chef/health and safety, and one activity coordinator) contained all relevant employment documentation. The recruitment and staff selection process require that relevant checks are completed to validate the individual’s qualifications, experience and suitability for the role. Performance appraisals were current. Current practising certificates were sighted for the facility manager, nurse manager and allied health professionals. The number of staff files were extended to evidence completion of medication competencies and first aid certificates.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. The service has initiated a full day compulsory training day that includes infection control, health and safety, fire warden training, clinical updates and manual handling by the physiotherapist. The training day is interactive with videos, practical demonstrations, quizzes and questionnaires. Staff feedback has been positive, and the service is now extending to 1.5 days. Staff have access to training on-line and health and wellbeing unit standards. A laptop is available for staff to use for education. One-on-one staff training, and support is provided. Monthly in-services include guest speakers. Clinical staff complete competencies relevant to their role including medication competencies, manual handling and wound care. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and nurse manager are on-site Monday to Friday. The HCAs, residents and relatives interviewed inform there are sufficient staff on duty at all times.  The facility has three wings (one 13 beds, one 12 beds and one 10 bed). On the morning shift there are two HCAs (one 7.00 am - 3.30 pm and one 6.00 am - 2.30 pm). On the afternoon there is one HCA on the full shift and one short shift who also completes the dinner service and supper. On the night shift there is one HCA from 11.30 pm to 7.30 am and one available on-call.  An activity coordinator is employed four days a week. There is a cook on duty daily from 7.00 am to 1.00 pm. There are designated cleaning and laundry staff. |
| 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. 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 | The entry to the service policy includes requirements and procedures to be followed when a resident is admitted to the service. Admission agreements were signed in all resident’s records sampled. Admission agreements reflect all the contractual requirements. Residents and families reported that the manager (RN) discussed the admission agreements with them in detail. All residents had the appropriate needs assessments prior to admission to the service. A pamphlet containing information about the service was sighted. The nurse manager ensures that residents are admitted to the service as per contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | A standard transfer notification form from the district health board is utilised when residents are transferred to the public hospital or to another service. The yellow envelope is used with the transfer notification form. The facility manager and nurse manager verbalised that telephone handovers are conducted for transfers to other providers. The residents and their families were involved in all exits or discharges to and from the service. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The facility uses a paper-based system and blister packs for medication administration. Staff administering medications complied with the medication administration policies and procedures in the observed medication round. Care staff administering medications had completed annual medication competencies and annual medication education.  All medications were stored appropriately. No residents self-administer medications. The self-administration policies and procedures were in place. Medication records were viewed for 10 residents and met legislative prescribing requirement. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. The cook prepares and cooks meals on-site. All staff have had food safety training. There is a food services manual in place to guide staff.  Residents are provided with meals that meet their food, fluids and nutritional needs. The nurse manager completes a resident nutrition profile form on admission and provides a copy to the kitchen. This document is reviewed at least six monthly as part of the care plan review. Additional or modified foods are also provided by the service.  Fridge and food temperatures were monitored and recorded daily. All food is stored appropriately. The cooks follow a rotating seasonal menu which has been reviewed by a dietitian. Cooked meals are plated from the kitchen directly to the dining room. The meals were well presented, and residents confirmed that they are provided with alternative meals as per request. All residents are weighed regularly. Residents with weight loss are provided with food supplements.  Residents and the family/whānau members interviewed were very happy with the quality and variety of food served. |
| 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 | There is a documented policy on decline of entry to the service. When a resident’s entry to the service is declined, the resident is referred to the referrer to ensure that the resident is admitted to the appropriate level of care provider. The facility manager reported that the district health board needs assessors, and social workers contact the facility manager to discuss the suitability of the resident prior to sending the resident’s family to view the facility. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. Appropriate assessment tools including the interRAI were completed, and assessments were reviewed at least six monthly or when there was a change to a resident’s health condition in files reviewed. Care plans reviewed were developed based on these assessments. |
| 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 sampled were resident-focused and personalised. The care plans describe the resident goals, supports and interventions required to meet desired goals as identified during the ongoing assessment process. There is documented evidence of resident and/or family input ensuring a resident-focused approach to care. Residents/relatives confirmed on interview that they are involved in the care planning and review process. There was evidence of allied health care professionals involved in the care of the resident. Short-term care plans were evident in the sampled files. Interventions were sufficiently detailed to address the desired outcome/goal. Integration of records and monitoring documents are well managed. |
| 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 alters, the registered nurse initiates a review and if required, arranges a GP visit. There is evidence of three monthly medical reviews or earlier for health status changes. Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations. Family confirmed they are kept informed of any changes to residents’ health status. Family members interviewed expressed satisfaction with the clinical care and that they are involved in the care planning of their family member. Health care assistants interviewed state there is adequate equipment provided including continence and wound care supplies. On the day of the audit, supplies of these products were sighted.  There was one venous ulcer being treated at the time of the audit. Wound assessments had been completed with ongoing evaluations documented. The nurse manager interviewed could describe the referral process to a wound specialist or continence nurse. Monitoring occurs for weight, vital signs, blood glucose and challenging behaviour.  Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity, and weight loss. Health care assistants interviewed confirmed they are updated of any changes in residents’ care or treatment during handover sessions at the beginning of each shift. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs an activities coordinator from 10.00 am to 4.30 pm across four days a week. Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. The activity therapist interviewed, has been in the role for three years and displayed a comprehensive understanding of requirements. Health care assistants support all activities.  The weekly activities are posted on the wall and in each resident’s room. Activities include (but are not limited to) van outings, entertainment, walking groups, bowls, bingo, church services and quizzes. The activity plans sampled were well documented and reflected the residents’ preferred activities and interests. Each resident has an activities assessment profile on admission and from this information an individual activity care plan is developed. The activities plan is reviewed six monthly and the reviews document the resident’s progress towards goals. The residents’ activities attendance was sighted. Residents and families indicated the activities provided by the service are adequate and enjoyable. On the day of audit, residents were observed being actively involved in an activity in the main lounge. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurse evaluates all initial care plans within three weeks of admission. All residents have a long-term care plan, and evaluations document progress towards goals under each section. One resident does not yet require a care plan evaluation. Changes in health status were documented in the care plan or a short-term care plan developed. Care staff document progress notes on every shift. Registered nurse entries in progress notes were evident. The GP completes a three-monthly resident review or earlier if required. Family are notified of GP visits and three-monthly reviews by phone call and if unable to attend, they are informed of all changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | There are documented policies and procedures in relation to exit, transfer or transition of residents. There is evidence of referrals by the GP to other specialist services. Residents and families are kept informed of the referrals made by the service. The facility manager and/or nurse manager facilitates internal referrals. |
| 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 | Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety material datasheets were available and accessible in all service areas. The hazard register is current. Staff interviewed confirmed they could access personal protective clothing and equipment at any time. As observed during the audit, staff were wearing gloves, aprons and hats when required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. The facility has a current building warrant of fitness that expires 14 October 2018.  Reactive and preventative maintenance is completed by a maintenance person and external contractors are available as needed. Electrical safety test tag-system shows this has occurred. The facility is being maintained in good repair. All maintenance records were reviewed and are clearly documented. Review of the records reveals temperatures are all below 45 degrees Celsius and whenever it was out of range, corrective actions have been taken.  All external areas inspected were safe and contain appropriate seating and shade.  Interviews with residents and family members confirmed the environment was suitable and safe to meet their needs.  Health care assistants interviewed confirm there is sufficient and appropriate equipment available to safely deliver resident care as described in care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Several bedrooms have their own ensuites and four have shared ensuites. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| 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 | There is adequate space in the bedrooms and enough space for the safe manoeuvring of mobility equipment. Residents can personalise their rooms. |
| 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 | The communal areas include the main lounge and dining area and a second lounge and dining area. In addition, there are a number of smaller lounges spaced throughout the facility. The communal areas are easily and safely accessible for residents. |
| 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 | Cleaning is completed by dedicated housekeeping staff. There is a designated laundry and cleaning person. There are sufficient staff allocated seven days a week to carry out these services. The service conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. Where improvements can be made these are implemented. Current safety material datasheets about each product are located with the chemicals. The chemicals are stored appropriately in locked cabinets at all times. The cleaner’s trolley is stored in a locked room when not in use. The chemical mixes are prepared from a wall-mounted system, which works effectively. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency, disaster policies and procedures are documented for the service. The service has an approved fire evacuation scheme that has been updated 20 February 2018. Fire drills occur every six months (last fire drill occurred November 2017). The orientation programme and annual education/training day includes fire and emergency training. Staff interviewed confirmed their understanding of emergency procedures. The service was commended for an actual full evacuation recently due to a gas leak at the roadside. 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 supplies. A gas BBQ is available for alternate cooking. There is emergency lighting and the service hires a generator as needed. A call bell system is in place including all resident rooms and communal areas. There is at least one staff member on duty 24 hours 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 | The rest home has adequate heating. The maintenance person interviewed, ensures the heating systems are running smoothly and that appropriate checks are performed.  There are sufficient doors and external opening windows for ventilation. All bedrooms have external opening windows which are designed and installed to promote ventilation and to be secured as needed.  The residents and family interviewed, confirmed the internal temperatures and ventilation are comfortable during the summer and winter months. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The nurse manager has the overall responsibility for infection control across the facility. Responsibility for infection control is described in the job description. The infection control coordinator is responsible for the collation of monthly infection events. The infection control programme is reviewed annually by the management team and relevant staff across the service.  Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the influenza vaccine. There have been no outbreaks. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control coordinator has completed MOH on-line education within the last year and has attended external wound care education. There is access to infection control support and advice within the Cavell group of infection control coordinators, expertise within the DHB, wound nurse specialist, health promotion unit and the laboratory. The GP monitors the use of antibiotics. |
| 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 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 the Cavell group and reviewed regularly. |
| 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 provides training on infection control at orientation. Annual education continues as part of the compulsory education day and includes questionnaires and hand hygiene audits.  Resident education is expected to occur as part of providing daily cares. |
| 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 | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator submits surveillance numbers to the Cavell group administrator who generates benchmarking graphs of infections against the other four facilities. Infection control data, trends and analysis is discussed at the management and staff meetings. Trends are identified and analysed, and preventative measures put in place. Graphs and meeting minutes were sighted on the staff office noticeboard. The results of surveillance are used to determine infection control activities and education needs in the facility.  Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks.  Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The nurse manager is the designated infection control person. Monthly infection data is collected for all infections, based on signs and symptoms of infection. Surveillance of all infections is entered into a monthly summary. It is then analysed and reported to staff meetings. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies and procedures around restraints and enablers that reflect best practice and include the definitions of enablers and restraints. The nurse manager is the restraint coordinator. No residents were using restraints or enablers on the day of audit.  Staff receive training around restraint minimisation and managing challenging behaviours and complete a competency questionnaire. Health care assistants interviewed, were able to describe the difference between an enabler and a restraint. |

# Specific results for criterion where corrective actions are required

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

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

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

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

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

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

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

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

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

End of the report.