# MorningView Health Care Limited - Rose Garden Rest Home

## Introduction

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

The audit has been conducted by Q-Audit 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:** MorningView Health Care Limited

**Premises audited:** Rose Garden Rest Home

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

**Dates of audit:** Start date: 24 April 2018 End date: 24 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.

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

Rose Gardens Rest Home is governed by two directors. The service provides rest home level care for up to 40 residents. There were 22 residents on the day of the audit. An experience registered nurse has been appointed as the facility manager since the last audit.

This unannounced surveillance audit was conducted against a sub set of the Health and Disability Services Standards and the provider’s contract with the district health board (DHB). The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family, one general practitioner (GP), the directors, management and staff.

The previously identified area requiring improvement regarding maintenance in one bathroom has been met. There were no areas requiring improvement identified during this 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. |

Communication systems are appropriate to the needs of the residents. Sufficient information is made available. Interpreter services can be accessed if required. Interview with residents and family confirmed open communication opportunities with management and staff.

The complaints process is accessible. Records of complaints sampled confirmed appropriate and timely responses. A register is maintained. There had been one complaint made to external authorities since the last audit. This has been addressed and is now considered closed.

## 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 directors monitor organisational performance. The mission and vision statements are identified in the business plan.

The quality and risk management system is fully implemented. Quality data is collated and analysed and the organisation routinely conducts opportunities to continually improve their services. Policies and procedures are current. Adverse events are documented, investigated and closed in a timely manner.

Human resources processes ensure an adequate number of suitably qualified staff are on site over the 24-hour period. Competencies are maintained and there are sufficient staff on duty at all times.

## 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. |

Assessments, care plans and evaluations are completed by the facility manager, who is a registered nurse, within the required timeframes. Staff and family members are involved in the planning and evaluating of care. Care plans are evaluated six-monthly or more frequently when clinically indicated. Short term care needs are documented. The GP reviews the residents at least three monthly.

The activities programme focusses on meaningful activities that meet the individual abilities and recreational preferences of the residents.

The medication management system follows the recognised standards and guidelines for safe medicine management practices. Staff who administer medications are assessed as competent.

Meals are prepared and cooked onsite. Individual and special dietary needs are provided as requested.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

There have been no changes to the facility since the last audit. There is a current building warrant of fitness.

## Restraint minimisation and safe practice

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

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

## 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 type of surveillance is appropriate to the size and complexity of the service. The infection rates are benchmarked and discussed in the monthly staff meetings.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 17 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints policy complies with Right 10 of the Code. The service has an up-to-date complaint register which identifies: the date the complaint was received; who is responsible; the date actioned and the date closed. Follow up actions are clearly documented. Records of complaints sampled confirmed that the complaints process is well managed and meets requirements. There is evidence that all complaints are taken seriously. Complaint forms are clearly displayed and are available to residents and family members. Management and staff verbalised their understanding of the complaints procedure to meet policy requirements. Residents’ meetings provide residents with the opportunity to provide feedback regarding their satisfaction. There were no concerns voiced by residents or family members interviewed during the audit.One complaint (which was received in August 2017) was forwarded to the Health and Disability Commissioner. This complaint was investigated by the DHB. Records sampled included a letter from the DHB confirming closure and a letter from the Commission stating that no further action is required. Opportunities for improvements were discussed at a staff meeting.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The adverse event and complaint procedure alert staff to their responsibility to notify the residents’ families or next of kin in a timely manner. There is an open disclosure procedure. Records sampled confirmed that family members are contacted by the facility manager when an incident occurred. Family members interviewed confirmed that they are kept informed as and when required. Records of family contact are maintained.There were no residents who required interpreter services at the time of the audit, however interpreter services are available through the local district health board if required. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | There have been no changes to governance since the last audit. There are two owners/directors both of whom work onsite Monday to Friday and are available after hours if needed. The directors maintain their ongoing education requirements regarding the aged care sector and management. The directors develop the business plan and monitor organisational performance. The mission, values and vision remain unchanged following the last business plan review.A facility manager has been appointed since the last audit. The facility manager commenced in July 2017 and is a registered nurse with many years’ experience (both clinical and management) in the aged care sector. The facility manager is on site Monday to Friday and available after hours. The facility manager is supported by a residential care officer and another senior care assistant for the day to day management of service delivery, however both the directors are also actively involved. The organisational chart has been updated to reflect the changes in management. The facility has three wings called ‘Lodges’ and one stand-alone building referred to as the ‘House’. At the time of this audit only the Lodges were occupied by 22 residents. The House is not currently in use. One resident has been assessed as hospital level care for which the Northland District Health Board (NDHB) and the Ministry of Health have agreed to under certain documented conditions which the facility adhere to.  |
| 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 | There is a documented quality and risk management system. All the required policies and procedures are documented and accessible to staff. Procedures reflect current good practice and are referenced to legislative and standard requirements. The facility manager is delegated the responsibility for ensuring policies and procedures are current. A range of quality activities are documented. This includes: the collection and collation of quality data including the results of internal audits; incident and accident reports; health and safety reporting infection control data; restraint; complaints and resident satisfaction surveys. Clinical indicators are forwarded to an external benchmarking programme. There is evidence in quality records sampled that service improvements are discussed and implemented as and when required. Quality related information is shared with all staff as confirmed in meeting minutes sampled. Both owners attend the monthly staff meetings and are aware of quality actions completed or those to be taken. Monthly residents’ meeting minutes sighted also confirm that resident feedback is sought and corrective actions put in place as required.The business risk management plan includes the identification of actual and potential risks. Each organisational risk is rated against the impact on the service and the likelihood of occurrence. Preventative actions are documented. One of the directors is the health and safety representative and has a background in safety management. Newly found hazards are discussed at staff meetings and residents are informed as appropriate. A hazard register is maintained.  |
| 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 | The process for managing all adverse events is documented. The facility manager confirmed awareness of the requirements related to statutory and or/regulatory reporting obligations. There is evidence that the required notifications were made in relation to specific incidents. Records of adverse events sampled confirmed the required emergency management and follow up investigations were completed. Family were notified as required. Incident and accident forms are collated monthly and used for benchmarking purposes. The collation includes a monthly analysis with other similar facilities and comparisons with previous months. An incident register is maintained and confirmed that events documented in resident records had been added to the register. The required remedial actions were documented. All adverse events are discussed during staff meetings. This includes discussions regarding any remedial actions. |
| 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 | All staff have a job description that describes their responsibilities and lines of reporting. This includes the position description for the facility manager and senior staff members such as the residential care officer and the health care assistant team leader.Staff complete an orientation programme with specific competencies for their roles. Documentation in the staff files sampled confirmed some competencies, such as medication management are repeated annually. Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. Employment processes included reference checking, police vetting and gaining signed employment agreements. The current education calendar sighted identifies that staff undertake training and education related to the roles they undertake. Topics covered in annual training and education relate to age care and health care services. Members of the management team also attend workshops and seminars specific to management related topics. Education occurs both on and off site. Healthcare assistants are encouraged and supported to undertake recognised aged care qualifications and the facility manager is an assessor. Individual training records and attendance is maintained.Staff performance is monitored. The senior staff monitor the health care assistants’ performance monthly and the facility manager has completed a performance appraisal for the two senior staff members. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Staffing levels and skill mix are documented and maintained to meet residents’ needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified and experienced staff are on duty to provide safe and quality care. The facility manager who is a registered nurse works Monday to Friday and is on call. The directors are also available over the 24-hour period if needed. The roster confirmed that there is always a senior team member on duty. The organisation is currently recruiting for another full time registered nurse. Rosters sampled confirmed that staff were replaced for sickness and annual leave. Staff are provided with the opportunity to request shifts that best meet their individual needs. These are approved by the director and the facility manager. Staff who are orientating are additional to the roster while they are being supervised. There are dedicated kitchen staff seven days a week, an activities coordinator five days a week and dedicated cleaning hours are identified on the roster. Healthcare assistants undertake the laundry as part of their daily duties.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management system complies with legislation, protocols, and guidelines. Residents receive medicines in a safe and timely manner. All medications are reviewed as required and discontinued medications are signed and dated by the GP. Allergies are clearly documented, photos are current and three-monthly reviews are completed. Medication charts are legibly written. The medication and associated documentation are stored safely and medication reconciliation is conducted by the facility manager when a resident is transferred back to service. The service uses pre-packaged packs. There were no expired or unwanted medications. Expired medications are returned to the pharmacy in a timely manner. There were no residents on controlled medication. There were no residents self-administering their medication.An annual medication competency is completed for all staff administering medications and medication training records were sighted. The staff member was observed administering medications safely and correctly. |
| 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 | Meal services are prepared on site and served in the allocated dining room. The service employs two cooks who work from Monday to Friday and weekends respectively with oversight from one of the directors who is a qualified chef. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four-weekly rotating winter and summer menu in place.The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness of dietary needs required by the service. Meals are served warm in sizeable potions required by residents and any alternatives are offered as required. The residents’ weights are monitored monthly and supplements are provided to residents with identified weight loss issues.The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is completed. The residents interviewed acknowledged satisfaction with the food service. The grading certificate for a new operator registration under Food Control Plan Act 2004 was sighted and the kitchen is due to be audited by the council to meet safe food standards. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in long term support care plans are sufficient to address the residents’ assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily, as confirmed by the GP. Nursing treatment and progress notes are completed on every shift. Adequate clinical supplies were observed and staff confirmed they have access to enough supplies. Residents interviewed reported satisfaction with the care and support they are receiving. |
| 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 | Residents’ activities are appropriate to the needs, age and culture of the residents. The service employs three activities coordinators two of which are in training to be diversional therapists (one of whom is one of the directors). An activity planner is developed and daily/weekly activities are posted on the notice boards and distributed to others. Residents’ files have a documented activity plan that reflects the residents’ preferred activities of choice. A monthly report is compiled reviewing the programme and any changes made are communicated to the residents. Individualised activity plans are reviewed every six months or when there is any significant change in participation and this is completed in consultation with the facility manager.Regular activities include (but are not limited to): tai chi; bingo; darts; van trips; exercises/walking and church services; happy hour; newspaper reading; bowls; quiz; dog therapy and music. The service has a volunteer who comes once a week to talk to residents individually. The activities coordinator reported that they have group activities and engage in one on one activities with some residents. Over the course of the audit residents were observed being actively involved in a variety of activities. Residents interviewed expressed satisfaction with the activities in place. Activities are modified to varying abilities and cognitive impairment. The residents’ activities participation register was sighted. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ long-term support care plans, interRAI assessments and activity plans are evaluated at least six monthly and updated when there are any changes. Family/whanau and staff input is sought in all areas of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term needs are fully documented in the nursing treatment and progress notes. |
| 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 have been no changes to the facility since the last audit. There is a current building warrant of fitness. Fire evacuation drills are conducted every six months as required.  |
| 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 | The previous area requiring improvement regarding one of the bathrooms in the ‘House’ has been fixed, however this facility is currently not being used for residential services. |
| 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 | Surveillance for infection rates is carried out in accordance with agreed objectives, priorities, and methods specified in the infection control programme. It is appropriate to the size and setting of the service. Infection rates and antibiotics use are monitored and recorded. Data is collated and analysed by the facility manager. Infection rates are discussed during staff meetings. Specific recommendations and interventions to reduce, manage and prevent the spread of infections are discussed in staff meetings as well as during hand-overs. An infection control summary and analysis for the year ending 2017 was sighted. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint minimisation policy provides consistent definitions for restraints and enablers. No residents were restrained and there was one resident was using an enabler. All staff receive education regarding restraint minimisation and challenging behaviours. Staff interviewed are aware of the difference between a restraint and an enabler. |

# 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.