

Metlifecare Coastal Villas Limited - Metlifecare Coastal Villas

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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

| | |
|---|--|
| Legal entity: | Metlifecare Coastal Villas Limited |
| Premises audited: | Metlifecare Coastal Villas |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 21 August 2018 End date: 22 August 2018 |
| Proposed changes to current services (if any): | To add medical non-acute services |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 34 |

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

| Indicator | Description | Definition |
|---|---|--|
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |

| Indicator | Description | Definition |
|-----------|--|---|
| | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
| | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

General overview of the audit

Metlifecare Coastal Villas offers rest home and hospital level care for up to 35 residents. The facility has made a request to add hospital non-acute medical services for 30 beds within the care facility area and suitability to add this service is included in this audit. The service is operated by Metlifecare Limited and managed by an experienced registered nurse who has been in the role for three years. The nurse manager is accountable to the village manager who is also a registered nurse. Residents and families spoke positively about the care provided.

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

This audit has resulted in one continuous improvement rating related to the use of quality data analyses and evaluation to assist in making improvements to services offered. There are no areas identified as requiring improvement from 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. |
|--|--|--|

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

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


Business and quality and risk management plans include the scope, direction, goals and values of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection, analysis and trending of quality data. Information is used to improve services as appropriate. There is well documented analysis and evaluation processes. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staff training reflects the skill level of staff. Staff education content showed that training is maintained by staff to allow them to safely manage all residents' needs. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

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

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical and medical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating. The furniture, equipment, and physical environment allows for safe services to be offered. The care unit has appropriate equipment and bedroom space to allow for the additional management of medical (non-acute) residents.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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

The organisation has policies and procedures that support the minimisation of restraint and encourage a restraint free environment. Four enablers were in use at the time of audit. There were no restraints in use. Restraint documentation describes a comprehensive assessment, approval and monitoring process with regular reviews, should restraint be used. Policy states the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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 prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 45 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 1 | 92 | 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](#).

For more information on the different types of audits and what they cover please click [here](#).

| Standard with desired outcome | Attainment Rating | Audit Evidence |
|---|-------------------|---|
| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need</p> | FA | <p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.</p> |

| | | |
|--|----|--|
| to make informed choices and give informed consent. | | |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | FA | <p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The noticeboard in the lounge provides the names and contact details for the resident's advocate, kaumatua and pacific islander advocate based in the community and support person for spiritual guidance.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. There are five residents who are supported to continue attending and being a part of regular community events.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The complaints/concerns/issues policy and associated feedback forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Forms are available at the entrance of the facility.</p> <p>The complaints register reviewed showed that 17 complaints of a minor nature have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. All complaints and follow-up actions are documented in both hardcopy and electronically. Metlifecare's senior clinical group view all complaints. Action plans showed any required follow up and improvements have been made where possible. The nurse manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p> |

| | | |
|--|-----------|---|
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | <p>FA</p> | <p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in the main foyer areas together with information on advocacy services, how to make a complaint and feedback forms and suggestions box. A copy of the Code of Rights was also observed in each of the resident's bedrooms.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | <p>FA</p> | <p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room, with one resident sharing two rooms with their spouse.</p> <p>Residents are encouraged to maintain their independence by attending community activities and participating in clubs of their choosing. Residents have the option of remaining with their own GP and two residents continue to do so. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p> | <p>FA</p> | <p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The senior registered nurse interviewed reported that there were currently no residents who affiliated with their Maori culture and there were no barriers in supporting residents who are admitted to the facility who identify as Māori. There is no specific Maori health plan; however, all values and beliefs of the resident would be integrated throughout the resident's long term care plan. There is acknowledgement of the Te Whare Tapa Wha model with input from cultural advisers within the local community as required to help support and develop a Maori health care plan for residents. With the resident's consent, a referral form is completed and sent to the local rohe for ongoing support. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</p> |

| | | |
|--|-----------|--|
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>FA</p> | <p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | <p>FA</p> | <p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included knocking on doors before entering, the use of privacy signs on the bedroom doors of residents when cares are being carried, the welcoming of families when visiting, and day to day conversations between staff and residents. Residents are acknowledged by their preferred name.</p> |

| | | |
|---|-----------|--|
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required to support the two residents with English as a second language, due to the use of and regular visits of family members, communication cards and the staff knowing the residents well. There are five residents with a significant sensory impairment and appropriate equipment and resources were sighted and highlighted in the residents' long-term care plans reviewed, for example, the use of white communication boards, a larger call bell, providing clear conversation and staff allowing time for the resident to respond. The residents and staff have also access to a Parkinson's Disease resource nurse and speech language therapist.</p> <p>Each month an updated activities calendar is provided to each resident's room along with the names and designation of the senior registered nurse and nurse manager.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. Coastal Villas have developed site specific goals which are clearly linked into the organisation's business and strategic planning process. The documents describe annual and longer term objectives and the associated operational plans. A sample of quarterly reports to the board of directors showed adequate information to monitor performance is reported including financial performance, complaints, quality indicators, resident care, quality projects and initiatives, internal audit results, staff training and education and emerging risks and issues. The nurse manager is also required to report weekly to the senior clinical quality and risk manager regarding all quality and risk matters.</p> <p>The care service is managed by a nurse manager who reports to the village manager. Both managers are registered nurses with current annual practising certificates. They maintain their skills and knowledge via ongoing education and training for both clinical and managerial topics. Examples included attendance at on-site education, actively participating in Metlifecare clinical governance group training and off-site training such as attendance at Capital and Coast District Health Board (CCDHB) meetings, dementia care education (Dementia Wellington), business training and first aid. The nurse manager has been in the role for three years and the village manager has held the position for 14 years. Responsibilities and accountabilities are defined in a job description and individual employment agreement.</p> <p>There are three members of the management team, the two before mentioned and the maintenance manager. (The nurse manager was not present at the time of audit owing to an unexpected family matter). Management are supported by the organisation's quality and risk manager and a team of registered nurses which includes a nominated senior registered nurse. The village manager and senior registered nurse confirmed their knowledge of</p> |

| | | |
|---|----|--|
| | | <p>the sector, regulatory and reporting requirements.</p> <p>The service holds contracts with the CCDHB for Age Related Residential Care and Short Term Residential Care. Thirty-four residents were receiving services under ARCC at the time of audit, being 28 hospital level care and six rest home level care. (Four rest home level care residents who hold an Occupational Right Agreement and live in serviced apartments are included in this number). The service has Ministry of Health approval to have five serviced apartments occupied as rest home level care. The main care facility has 30 dual purpose beds. No residents were under Short Term Residential Care on the days of audit.</p> <p>The service has applied for the 30 beds, located in the care facility which are currently approved as dual purpose beds (either hospital or rest home level care) to also be used for non-acute medical services. The five dedicated rest home level care beds in the personal suites are excluded.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>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.</p> | FA | <p>When the village manager is absent, the nurse manager and organisational operational manager carries out all the required duties under delegated authority. When the nurse manager is absent the senior registered nurse and clinical quality and risk manager, with oversight of the village manager, perform the clinical management role. All staff are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p> | FA | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, pressure injuries and falls, and wound care. Quality improvement data is clearly documented with analysis and evaluation shown. It is used at facility level for the development of specific projects, such as call bell response times and soft tissue injury prevention, to improve services. The manner in which the corrective actions are developed into projects is documented using current best practice to show the analysis, review and evaluation processes. This has gained the service a continuous attainment level.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality management team meetings, at the senior Metlifecare clinical meetings, at</p> |

| | | |
|--|-----------|---|
| <p>continuous quality improvement principles.</p> | | <p>board level and at staff meetings. Quality reporting is linked to organisational goals and the quarterly report to the board covers each goal set and what actions have been taken to achieve the goals.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities, implementation of corrective actions and monitoring and reporting of special projects. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey results (July 2018) showed that resident support, family being made to feel welcome, personal safety and security and quantity of food were the service strengths. It was difficult to make direct comparisons with the 2017 satisfaction survey as the wording in many of the questions in the 2018 survey had been changed to enable the organisation to gain a more in-depth response. However, opportunities for improvement were identified in the following areas; complaints management, medical care, availability of care staff and being able to share meals with friends and family. Whilst medical care gained a 96% overall rating, specific areas related to involvement in health-related decisions and explanations and information shared by medical staff scored poorly with an average score of 64%. This was discussed with the GP who stated that a meeting had been held and one corrective action had been developed to increase the time shared with family members and resident review meetings are to be increased throughout the year. The GP stated that the care provided by staff was of a high standard and that staff were always professional and knowledgeable. The GP supported the facility's application for non-acute medical certification. There were no negative comments received from residents or family members during the interviews conducted on the days of audit. The village manager stated that the action plan to address the findings of the 2018 satisfaction survey is being developed at senior management level with input from the quality team. A draft copy of the work undertaken up to the time of audit was sighted.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The senior registered nurse and village manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. This is supported by documentation sighted such as area specific risk management plans. Management are familiar with the Health and Safety at Work Act (2015) and have implemented requirements.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p> | <p>FA</p> | <p>Staff document adverse and near miss events on an accident/incident form or directly into an electronic tracking system. A sample of incidents forms reviewed and the electronic data base showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the nurse manager, the Metlifecare senior clinical team and the quality committee. Short term care plans are put in place to address any issues that arise, such as the need for a GP review, wound care or other safety interventions. Family are informed of all adverse events.</p> |

| | | |
|---|-----------|---|
| <p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | | <p>The village manager and senior registered nurse described essential notification reporting requirements, including for pressure injuries. They advised there has been two notifications of significant events made to the Ministry of Health, using section 31 reporting, since the previous audit. One related to an unstageable pressure injury in April 2017 which is now healed and one regarded a resident who went missing in May 2017. All appropriate documentation was completed including a police report for the missing resident who was found the same day. There have been no coroner's inquests, issues-based audits or any other notifications to the public health since the previous audit.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period and then annually. Resident and family interviews confirmed they are happy with way services are delivered by knowledgeable and professional staff. This was supported by the GP during a telephone interview.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Education covers a wide range of topics and is appropriate for non-acute medical care. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Two staff member are internal assessors for the programme. There are three trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. One casual registered nurse also holds current competencies for interRAI.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p> | <p>FA</p> | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. The staff levels sighted on the rosters matches the interRAI acuity report.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is</p> |

| | | |
|--|-----------|--|
| <p>and/or experienced service providers.</p> | | <p>24/7 RN coverage. No changes in staffing mix or staffing numbers would be required for non-acute medical care coverage as there is no change in bed numbers. There are dedicated staff who work in the village area from 7am to 10.15pm. During this time these dedicated staff undertake cares for the residents in the personal care suites who hold an occupational right agreement (ORA) but are under the ARCC rest home level care contract. From 10.15 pm to 7am there is a night porter who responds to call bells in the village including the residents in the personal care suites. The night porter has completed the full orientation process and holds a current first aid certificate. During the night if personal cares are required by the rest home level care residents in the personal care suites they are undertaken by a caregiver from the care home and the night porter assists with cover in the care unit.</p> <p>There is an activities coordinator from 9.30am to 4pm Tuesday to Saturday. Dedicated laundry staff work 46 hours per week covering seven days and dedicated cleaning staff cover seven days a week. The nurse manager works Monday to Friday and is on call. The on call is shared with the senior registered nurse who also works Monday to Friday.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | <p>FA</p> | <p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been</p> | <p>FA</p> | <p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC service and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p> |

| | | |
|--|----|--|
| identified. | | |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | FA | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | FA | <p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage including the support of non-acute medical residents.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were two residents in the care home self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. There are four residents under rest home level care residing in the serviced apartments, staff support with the administration of their medication as prescribed. Medication was observed to be securely located in each of the resident's rooms, a pharmacy paper based generated medication sheet signed by the GP and signing sheet was sighted for each resident which included an up</p> |

| | | |
|---|----|--|
| | | <p>to date photo of the resident.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>The food service is provided on site by the village chef manager, three other cooks and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued (expires April 2019). Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The chef manager has undertaken a safe food handling qualification, with kitchen assistants also completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. The total numbers of beds would not change with the addition of non-acute medical residents. The chef manager interviewed stated that they can manage all menus and different food diets for all residents.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. There is a copy of the days menu on each of the dining room tables and care staff were observed to read the menu to residents sitting at the table. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided with the option of residents having their meals in their bedrooms.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is</p> | FA | <p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p> |

| | | |
|--|----|---|
| managed by the organisation, where appropriate. | | |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>Information is documented using validated nursing assessment tools such as falls risk, skin integrity, and nutritional screening as a means to identify any deficits and to inform care planning. This process would also apply for non-acute medical residents. The sample of care plans reviewed had an integrated range of resident-related information. InterRAI assessments are completed by one of three trained interRAI assessors on site which includes the senior registered nurse. One registered nurse who was interRAI trained has recently left the facility and one registered nurse interRAI trained is currently on maternity leave. There are two registered nurses who are booked in for interRAI training in November 2018 and there is also the availability of a casual registered nurse who is interRAI trained. Thirty of 34 residents have current interRAI assessments completed. One resident admitted to the facility one day ago is awaiting transfer of their interRAI file and three residents were due for their interRAI assessments on the 11, 16 and 19 August 2018. These are still within timeframe of August to be completed, with two currently in draft. Residents and families confirmed their involvement in the assessment process.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs including the admission and ongoing support of non-acute medical residents.</p> |

| | | |
|---|-----------|---|
| <p>Standard 1.3.7: Planned Activities</p> <p>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.</p> | <p>FA</p> | <p>The activities programme due to the recent resignation of the diversional therapist is currently provided by a health care assistant who has experience as an activities co-ordinator. The activities co-ordinator supports residents Tuesday to Saturday from 9.30 am to 4 pm. A contracted diversional therapist trainer visits the facility once a month and oversees the activities programme. The facility manager interviewed stated that recruitment of a diversional therapist is currently occurring.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. Once a week the residents are invited and encouraged to partake in entertainment and activities that are occurring in the village. The resident's activity needs are evaluated monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, satisfaction surveys. Residents interviewed confirmed they find the programme interactive.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. The medication electronic advice shows evidence of evaluations of residents who have had prescribed pro re nata (PRN) medications for pain. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or</p> | <p>FA</p> | <p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to a speech language therapist, occupational therapist and services for the older adult. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p> |

| | | |
|--|-----------|--|
| <p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | | |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p> | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this. This was confirmed during staff interviews. Correct use of protective clothing and equipment is managed by the health and safety committee who are involved in staff education and to ensure sufficient supplies are maintained.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>A current building warrant of fitness (expiry date 14 March 2019) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The service has adequate medical and lifting equipment to manage non-acute medical residents. The environment was hazard free, residents were safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>There is a process in place which staff use if any repairs or maintenance are required. Any requests are appropriately actioned. This was confirmed in the documentation sighted and during an interview with the maintenance person. Residents and family members confirmed they are happy with the environment.</p> |

| | | |
|---|-----------|--|
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p> | <p>FA</p> | <p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes all bedrooms in the care facility having a toilet ensuite and the five personal care suites in the serviced apartment area having full ensuite facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p> <p>The care suites enable staff to use lifting equipment if required and are suitable for non-acute medical residents. The bathroom areas in the personal care suites are too small to safely use lifting equipment and there is a lip on the exterior of the shower which would prevent safe use. Consequently, the five approved rest home level care beds in this area have been excluded from medical non-acute approval.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | <p>FA</p> | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. One husband and wife have chosen to use their adjoining rooms as one bedroom and one lounge. Rooms are personalised with furnishings, photos and other personal items displayed. The doorways to the bedrooms in the care unit (30) are of a size that is adequate for all equipment to be safely used and they are suitable for non-acute medical care.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p> | <p>FA</p> | <p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. The spaces are appropriate for non-acute medical residents.</p> <p>Residents in the personal care suites use the village dining area.</p> |

| | | |
|--|-----------|---|
| <p>accessible areas to meet their relaxation, activity, and dining needs.</p> | | |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | <p>FA</p> | <p>Laundry is undertaken on site by dedicated laundry staff who demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Both services can cater for non-acute medical residents as there will be no increase in bed numbers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and the use of chemicals is also monitored by the supplier of the chemicals who gives the provider a regular report.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | <p>FA</p> | <p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 20 March 2004. There has been no change in the footprint of the facility since this time. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 29 May 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's, were sighted and meet the requirements for the 35 residents. There is a generator on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular monthly basis and residents and families reported staff respond promptly to call bells. This is monitored by the nurse manager as part of the 'call bell project' using data gained by the off-site company who provides daily electronic reports on the response times.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the night porter undertakes checks the premises at night.</p> |

| | | |
|---|-----------|---|
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | <p>FA</p> | <p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light from opening external windows. Heating is provided by underfloor central heating and electronic ceiling heating which the resident can control in their bedrooms to keep it at a suitable temperature. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> |
| <p>Standard 3.1: Infection control management</p> <p>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.</p> | <p>FA</p> | <p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the gerontology nurse practitioner. The infection control programme and manual are reviewed annually.</p> <p>The senior registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the nurse manager and tabled at the quality/risk committee meeting. This committee includes the nurse manager, IPC coordinator, and representatives from care staff and registered staff and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p> | <p>FA</p> | <p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for five years. She has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p> |

| | | |
|--|----|--|
| infection control programme and meet the needs of the organisation. | | |
| <p>Standard 3.3: Policies and procedures</p> <p>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.</p> | FA | <p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in July 2018 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred in March 2018 where the facility had an upper respiratory infections outbreak.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p> |

| | | |
|---|-----------|--|
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | <p>FA</p> | <p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/senior registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the IPC coordinator and reported to all staff. Ninety five percent of residents and 70% of staff in May 2018 consented to the flu vaccine.</p> <p>The facility has had a total of 27 infections between January 2018 and June 2018. The residents' files reviewed highlighted short-term care plans. Surveillance data did not identify any residents who had frequent infections, however residents have been identified with an increased risk of infections due to co-morbidities. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is benchmarked internally within the group and externally three-monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>A summary report for a recent (March 2018) upper respiratory outbreak where five residents and three staff were affected, was reviewed and demonstrated a thorough process for investigation and follow up. The outbreak did not require a formal notification to the public health office. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, no residents were using restraints. Four enablers were in use. Enablers were the least restrictive and used voluntarily at the resident's request. A similar process is followed for the use of enablers as is used for restraints. This was confirmed in the residents' files reviewed for enabler use. Residents with an enabler have this clearly identified on their care plans and on the interRAI assessments.</p> <p>Restraint would only be used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. The restraint register identifies that no restraint has been used since the previous audit.</p> |

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.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
|--|-------------------|---|--|
| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | CI | <p>Quality and risk data are collected, analysed and evaluated. The results are communicated to all levels of the organisation from the board, clinical senior management, senior quality and risk team and all staff at the facility. Findings from the data collected are used to improve services as required, they are reflected in the annual goals of the facility in their annual quality goals and specific projects are developed to ensure goals are managed and reported against regularly. Two projects reviewed in depth at the time of audit are the call bell response times and the reduction of skin tears and soft tissue injuries. The call bell response times project is yet to be</p> | <p>All quality data is well documented and available electronically and in hard copy. A project related to the reduction of skin tears and soft tissue injuries which occurred between January and June 2018 showed relevant up to date research data formed the basis of the project and a detailed action plan was developed by the quality committee which identified the actions to be taken, who was responsible for each action, timelines were put in place and as each stage progressed and actions were completed they were signed off. The project evaluation identified that whilst the overall incidents of soft tissue injuries was not reduced, other benefits gained included staff having a better understanding of soft tissue injuries and in-depth training was given to staff regarding preventative measures, such as physiotherapy, input into manual handling education, ensuring all equipment is used correctly, awareness of environmental issues and nutritional needs to aid the resident’s healing process. This has resulted in staff being able to offer services in a knowledgeable manner which identifies that having fully attained the criterion the service can in addition clearly demonstrate a review process covering analysis and reporting of findings, evidence of action taken based on those</p> |

| | | | |
|--|--|---|---|
| | | evaluated but the skin tear and soft tissue injuries project is complete. | findings and improvements to service provision and resident safety. |
|--|--|---|---|

End of the report.