

Merivale Lifecare 2011 Limited - Merivale Retirement Village

Introduction

This report records the results of a Partial Provisional Audit; 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 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: Merivale Lifecare 2011 Limited

Premises audited: Merivale Retirement Village

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

Dates of audit: Start date: 4 March 2019 End date: 5 March 2019

Proposed changes to current services (if any): The service provider has built a new facility that has 47 dual purpose (aged care - rest home and hospital) beds upstairs and 22 apartments downstairs for supported living packages or rest home care. It is anticipated that some of the residents currently in the Merivale Retirement Village Rest Home, and all residents from the Silverdale Hospital next door who choose to, which is part of the Merivale Retirement Village, will transfer over to the new facility on 1 April 2019. Potential occupancy will reduce from 101 to 69.

Total beds occupied across all premises included in the audit on the first day of the audit: 51

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.

General overview of the audit

The Merivale Retirement Village has been providing rest home and hospital level care for up to 101 residents. The service is operated by Merivale Lifecare (2011) Limited and managed by a managing director and a nurse manager. A new hospital and rest home facility that will have a total of 69 beds has been built to replace the current facilities, which were damaged in the 2011 Christchurch earthquake.

This combined partial provisional and surveillance 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 management, staff and a general practitioner. Two residents only were informally interviewed and no relatives, which was a planned approach to reduce the impact of an audit on the service users who are experiencing significant changes.

This audit has resulted in two continuous improvement ratings, one in relation to a quality improvement approach around falls prevention and the other for management of an outbreak. There are six areas requiring improvement, five of which need to be addressed prior to occupancy of the new building. These relate to internal corrective action processes and the need for full compliance with building and equipment regulations, installation of the laundry, staff training on emergency management for the new build, an approved evacuation plan and for call bells to be operational. There were no corrective actions raised at either the previous certification audit, or at the partial provisional audit undertaken to confirm appropriateness of the Palazzo Studio units for rest home care.

Consumer rights

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
---	--	---

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

Residents and family members receive information about how to make a complaint. 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.		Some standards applicable to this service partially attained and of low risk.
---	--	---

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

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented and followed through. 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. Staffing levels and skill mix meet the changing needs of residents and plans are in place to ensure the safety of residents during and after the transfer to the new building.

Quality and risk management systems and human resources management overall are not expected to change when the services move across to the new facility.

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.
--	--	--

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The care plans are reviewed every six months or earlier if required, with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach. There are regular general practitioner reviews.

The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents.

Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education.

Residents' food preferences and dietary requirements are identified on admission. All meals are cooked on-site, taking into consideration any dietary preferences or needs.

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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

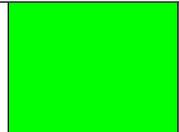
The building warrants of fitness for the rest home and hospital buildings in use were current.

Communal and individual spaces in the new building are modern, spacious, have appropriate heating systems in place and will provide residents and their visitors with options. External areas are accessible, safe, professionally landscaped and provide shade and seating.

Waste will continue to be managed by contractors and the maintenance person and there are safe storage areas for chemicals. Staff will have ongoing access to protective equipment and clothing. There is a purpose-built on-site laundry and space for the storage of cleaning chemicals and equipment.

Plans for staff to be trained in emergency procedures, use of emergency equipment and supplies and attendance at a fire drill in the new facility are in place. A call bell system was in the process of being installed and appropriate security systems for the new building have been planned.

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 implemented policies and procedures that support the minimisation of restraint. Two people were using an enabler at the time of audit. No restraints have been used in this facility for many years. 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 and associated policies and procedures are reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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	21	0	4	0	0	0
Criteria	2	51	0	6	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The compliments and complaints policy and associated forms meet the requirements of Right 10 of the Code. According to the nurse manager, she provides information on the complaint process to new and prospective residents and families at the time of enquiry and/or at the time of admission. In addition, documentation in the admission package, which was sighted, includes a section on how to make a complaint. The complaints and suggestions box with relevant forms are beside copies of the Code in the front entrance.</p> <p>The complaints register reviewed showed that there have been no formal complaints made since the beginning of 2019. Sixteen were recorded for 2018 and the register documentation showed that each had been investigated, responded to within the required timeframes, appropriate follow-up actions taken, improvements made and closure. Responsibility for complaints management and follow-up sits with the nurse manager, who informed she may seek assistance from the managing director, the clinical manager from the rest home or the charge nurse in the hospital when relevant.</p> <p>There have been no complaints received from external sources since the previous audit.</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>A policy and procedure on open disclosure was reviewed and meets the requirements of the Code. The nurse manager described examples of open disclosure having occurred at the Merivale Retirement Village and such examples were evident in residents' records reviewed. Other senior staff also reported their understanding of the principles of open disclosure. A sample of incident/accident forms verified contact with family members/next of kin after a resident has experienced an adverse event.</p> <p>The interpreter policy document clarifies the information that needs to be conveyed in a manner the resident(s) clearly understands. This document also noted how to ensure the communication needs of residents with special needs were accommodated and examples of implementation of this for people with visual and hearing impairments were provided. Senior staff reported that there has been no need to access interpreter services for many years but were aware of the interpreter services and who to contact for assistance.</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 business plan 2019 – 2021 was viewed. This outlines the vision and philosophy as well as the values, scope, direction and goals of the service provider. It also includes an environment analysis - a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis. The document described annual and longer-term objectives, key performance indicators, internal processes and associated operational plans. Each month, the nurse manager provides three reports to the managing director for the board of directors. These included a management report, a checklist and a completed quality improvement risk and management plan. Samples of these were sighted and confirmed the board is fully updated on a regular basis.</p> <p>The service is managed by a suitably qualified and experienced nurse manager who is a registered nurse with certificates in leadership and management and has been in the role for more than six years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Knowledge of the sector, regulatory and reporting requirements was confirmed. Currency of knowledge is maintained through attendance at aged care related conferences and seminars, quarterly infection prevention and control updates, Aged Care</p>

		<p>Association management days and any other relevant education sessions and days.</p> <p>The service holds contracts with the District Health Board under the Aged Related Residential Care Services Agreement to provide rest home and hospital level care (medical and geriatric) for the older adult. Respite care and end of life care is also provided under this agreement, as needed. Twenty-three residents were receiving rest home level care and 28 hospital level care up until midnight of the day of the audit. Two rest home residents left the facility the day of the surveillance audit.</p> <p>An interview with both the nurse manager and the managing director was undertaken for the partial provisional audit. The managing director confirmed that there are no immediate intentions to change the organisational structure of the service provider, which sits under Merivale-Willowlea Holdings Limited 2015. There are currently four people on the board of directors, who meet monthly. The managing director informed she meets with the nurse manager most days, confirmed the intended date to transfer the residents from the current Silverdale Hospital and Merivale Rest Home over to the new facility is 1 April 2019 and provided a copy of the transition plan. The transition plan details information provision processes, staffing goals, staff orientation and described the moving process. It was confirmed that there are no legislative compliance issues that could affect the service. All other current processes, including quality and risk management, policies and procedures, staff education, infection control, service delivery, documentation and staffing are expected to remain the same with no significant changes planned in the shorter term.</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>	<p>FA</p>	<p>During any absence of the nurse manager, the clinical manager, based in the rest home and the charge nurse – hospital, take on additional responsibilities under delegated authority. The managing director informed she also makes herself available and visits on a daily basis during such times. The nurse manager of a sister facility is informed and makes herself available should the need arise. During absences of key clinical staff, the clinical management is overseen by the nurse manager or one of the other registered nurses. These plans, which are reported as working satisfactorily, are not expected to significantly change with the transfer to the new building.</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 continuous quality improvement principles.</p>	<p>PA Low</p>	<p>A quality and risk plan dated 2018 – 2020, was in the quality manual and included goals, objectives, strategies and responsibilities. Reports from the nurse manager and meeting minutes confirmed that the quality and risk management plan is being implemented. The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal and external audit activities, a regular residents and family satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint, health and safety and reviews of policy and procedures documentation.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly quality and risk team meetings and again at staff meetings. Staff reported they are required to read staff meeting minutes if they have not attended; are required to complete documentation such as incident forms and some are involved in undertaking internal audits. An annual schedule for monthly internal audits was sighted. Relevant corrective actions are identified; however, it was difficult to see their follow-up since October 2018 and this was raised for corrective action. Resident and family satisfaction surveys are completed annually. The most recent survey showed food was an issue, as were the plans for the new facility. Staff are encouraged to take on quality improvement initiatives and several examples were sighted. A continuous improvement rating has been allocated for criterion 1.2.3.6 in order to acknowledge a significant decrease in the number of residents' falls following implementation of targeted strategies and ongoing reviews of their effectiveness.</p> <p>Health and safety has now been integrated into the wider quality and risk management system. The nurse manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> <p>Policies reviewed covered 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 following review in 2018. 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 identification, monitoring, review and reporting of risks and development of mitigation strategies are described in a risk plan. Various aspects of a quality improvement and risk management action plan are noted on a template that is</p>
---	---------------	---

		completed by the nurse manager on a monthly basis. Completed copies are provided to the board of directors through the managing director.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	FA	<p>Staff document adverse and near miss events on a hard copy accident/incident form. The nurse manager checks these, and an administrator enters the information into a database electronically. A sample of incident forms reviewed showed these were fully completed, incidents were investigated by the relevant person in charge of the area the incident occurred in, action plans were developed and actions followed-up in a timely manner.</p> <p>Adverse event data is collated, analysed and reported to the staff meetings, quality meetings and health and safety meetings. Incidents are escalated to the managing director when relevant.</p> <p>The nurse manager described essential notification reporting requirements, including for pressure injuries, disasters and specific infections. They advised there have been a stage three pressure injury, two infection outbreaks (one respiratory and one MRSA) and a coroner inquest reported to the relevant authorities.</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>	FA	<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. Records of orientation processes in staff files that were reviewed showed documentation of completed orientation and a review to identify any specific education requirements after a three to four-month period.</p> <p>Continuing education is planned on both an annual and biannual, which ensures all mandatory training requirements are covered. 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. A staff member is the internal assessor for the programme. There are seven trained and competent registered nurses who are maintaining their annual competency requirements to</p>

		<p>undertake interRAI assessments, which is enabling resident's interRAI reassessments to be kept up to date. Staff records reviewed also demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>There is no intention to change any aspect of the current human resources systems with the transfer across to the new facility at Somme Street.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</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). A separate rostering policy provides additional details and includes some specific rules about the number of consecutive shifts permitted and who will attend to call outs for example.</p> <p>Three previous weeks of roster, plus the current one, were reviewed and showed that the facility adjusts staffing levels to meet the changing needs of residents. Adequate staff cover has been provided, staff have been consistently replaced in any unplanned absence and staff with appropriate skills and experience are being allocated. Although no staff allocation acuity tool is in use, adjustments are made when a resident becomes unwell, or acuity increases. Leadership is identifiable on each shift. The registered nurse in the hospital is always in charge, but a team leader is allocated in the rest home area. There is 24 hour/seven days a week registered nurse coverage in the hospital.</p> <p>An afterhours on call roster is in place, with both a clinical on-call person (usually the nurse manager) and a roster on-call person to manage unplanned absences. Care staff reported there were adequate staff available to complete the work allocated to them. As all registered nurses, the diversional therapists and some senior caregivers have a current first aid certificate, there is always a person on duty with this competence. Staff with medication competencies are identifiable on the roster.</p> <p>All staff who are choosing to remain on the staff will transfer across when the residents move. The nurse manager informed that there will be additional staff rostered during the settling in period and daily assessments will be made to ensure residents' needs are met. There is mention of staffing in the transition plan reviewed.</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>	<p>FA</p>	<p>Medication management is implemented using a paper-based system and blister packs from a contracted pharmacy. All aspects of medication management are in line with those recommended by the Medicines Care Guide for Residential Aged Care. Medications are delivered to MRV and checked against the prescription and signed by an RN. Input is available from the pharmacist on request.</p> <p>Controlled drugs are stored securely in a double locked cupboard and always checked by two medication competent staff. The controlled drug register showed evidence of weekly and six monthly stocktake with accurate entries. Specimen signatures were sighted and updated six-monthly. Nonpackaged medications were stored in a locked cupboard and showed evidence of stock rotation. All medications sighted were within the recommended use by dates. Medication fridge temperatures were recorded and within the recommended range.</p> <p>Good prescribing practices were noted, including the prescriber's signature and date recorded on the commencement and discontinuation of medications. The reasons for pro re nata (PRN) medications met the required standard. The requirement for three monthly reviews by a GP was met and consistently recorded on the medication chart.</p> <p>At the time of audit there were no residents who self-administered medication.</p> <p>Storage systems for medicines in the new facility are to be in locked rooms requiring swipe access. These are set in nurses' stations, which can also only be accessed by authorised persons. There are plans in place to change to an electronic medicine management system once residents and staff have settled into the new building. There is wireless access throughout the building and staff training is expected to commence as soon as staff feel they are ready. The nurse manager informed that medicine management policies and procedures are expected to be amended to reflect the electronic system.</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>	<p>FA</p>	<p>The food service is provided on site in the rest home and delivered by hot boxes to the hospital and apartments. Temperatures of food were taken before and after delivery and were within recommended range. MRV menu follows a rotating four-week summer/winter cycle. The menu was last reviewed by a dietitian in November 2018 and was approved as suitable according to guidelines for nutrition in aged care. The service has an approved food safety plan as verified - 26 May 2018. The kitchen staff have all completed recognised food safety qualifications, as confirmed</p>

		<p>by the clinical manager. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complied with current legislation and guidelines.</p> <p>On admission a nutritional profile is completed detailing, allergies, likes, dislikes, portion size and special equipment required. These profiles were observed to be updated six- monthly. Residents with special dietary requirements, such as diabetic diet, were catered for. Of the seven residents' files reviewed weights were observed to be stable. The cook expressed that she was happy to make an alternative, such as an omelette, if a resident requested. Cakes are also created for birthdays and special occasions. A meal time observed during the audit was calm, unhurried and residents requiring help were assisted with dignity.</p> <p>The new building includes a ground floor kitchen and café. Most equipment had been installed by the time of the partial provisional audit but as identified in 1.4.2, electrical checks have yet to be completed. Food for all residents will be prepared in the kitchen according to current systems and the menu and current processes that accommodate individual dietary needs will remain the same.</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>	<p>FA</p>	<p>Documentation, observation and interview with the charge nurse verified that care provided to the residents was consistent with their needs, goals and plan of care. The interview with the GP confirmed that discussion and referral to allied health professionals took place in a timely manner. When medical input was required, he was notified promptly, and any medical orders were appropriately carried out.</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>Both the rest home and hospital had a suitably qualified activities officer. Planning and programming offered a varied programme, including newspaper reading, exercises, puzzles, bingo and visits from local school children. One to one activity was arranged for those choosing to stay in their rooms. Residents were free to choose which activities to attend. 'Happy hour' regularly included residents who had transferred to the hospital returning to the rest home to mix with old friends when possible. Resident meetings provided positive feedback of the programme.</p> <p>A social history is taken on admission detailing hobbies, interests and likes and dislikes which were used to formulate the programme. Residents social and activity needs are evaluated as part of the six-monthly care plan review.</p>

		Activities reflected the residents' goals, ordinary patterns of life and included normal community activities. In the rest home gender specific groups meet monthly and were appreciated by the residents according to the charge nurse. Family members were always welcome, and the activities officer confirmed active participation.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated each shift and documented in the progress notes. If any change is noted the RN is informed. Formal evaluation of care plans occur six-monthly in line with interRAI reassessments or sooner if a resident's condition changes. If interventions need to be changed, they are dated and signed, for example, if bruising is noted then 'apply arm protectors' may be added to the interventions. Short term care plans were sighted for infections and wound management with weekly updates or sooner if clinically allocated. Unresolved issues were transferred to the Long term care plan after two months. The charge nurse confirmed that family members were consulted during the evaluation process.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff currently follow documented processes for the management of waste and infectious and hazardous substances and there are no changes expected with the transfer to the new facility. An external company, which also provides relevant training to staff, is contracted to supply and manage all chemicals and cleaning products. This contract is to be maintained. Material safety data sheets were available where chemicals are currently stored and the nurse manager informed they will go across, as will the other related documentation. There is provision and availability of protective clothing and equipment.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	A current building warrant of fitness for the Silverdale Hospital building has an expiry date of 1 April 2019, while the Merivale rest home building warrant expires 1 October 2019. The new building was given a certificate of practical completion 28 February 2019; however, a Code of Compliance, or a Certificate of Public Use, has yet to be issued. Likewise, verification of the testing and tagging of electrical

		<p>equipment in the new building was not available at the time of audit.</p> <p>Appropriate designs have been implemented to ensure the residents' physical environment and facilities are fit for their purpose and are safe. Efforts have been made to ensure the environment is hazard free, easy for the residents to mobilise around and will enable them to maintain their independence.</p> <p>In addition to surrounding gardens, there is a rectangular shaped external inner courtyard that has been professionally landscaped with fountains, grass, paving and planting. A separate paved and planted courtyard is outside the bar area. There is level entry from all doors, both those from the residents' rooms and from the communal areas, which have automatic doors.</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>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the new facility. Each resident's room has its own ensuite with a toilet, shower and hand basin installed. There are three additional toilets for residents use downstairs and two upstairs. Appropriately secured and approved handrails are provided in all toilet/shower areas. Other equipment/accessories that promote residents' independence, such as shower chairs, will transfer across from the current facility.</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>	FA	<p>Adequate personal space that will allow freedom of movement is available in the new building with downstairs residents' apartments for supported living varying in size from between 38 and 44 square metres, including the ensuite. The dual purpose (suitable for hospital or rest home level care) rooms upstairs average 18 square metres, including the ensuite. Doors are wide enough to enable beds to be pushed through with ease. All bedrooms provide single accommodation, although are of sufficient size for a couple should this specifically be requested. According to the nurse manager, the residents will be encouraged to personalise their rooms as they currently do. There are specific storage bays and rooms for mobility aids and wheel chairs. A garage designed for mobility scooters has been included.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	FA	<p>A range of communal areas are available for residents in the new facility. The downstairs dining and lounge areas are open plan, spacious and are easily accessible. A café has been built into this area. Also downstairs is a purpose-built</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>bar with an outdoor seating area and two other smaller seating areas.</p> <p>Upstairs has a large television lounge and dining room, two smaller sitting areas and a library. An additional sitting area is beside the balcony that overlooks the internal courtyard.</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>PA Low</p>	<p>A laundry has been integrated into the new building and it is intended that all laundry, including personal items, will be undertaken on site. Dedicated laundry staff from the current facility will transfer across to the new building. A corrective action has been raised as on the day of the partial provisional audit, there was still no equipment installed in the laundry, nor cleaning/laundry fluid dispensers in place.</p> <p>Cupboards suitable for the safe storage of cleaning products and equipment are ready for the transfer of these items, including safety data sheets, from the current facility. Suitable locks have been fixed on the doors.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and results of the latest audits, with recommended actions having been completed, were viewed. The same system will be maintained.</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>PA Low</p>	<p>Policies and guidelines for emergency planning, preparation and response have been modified to reflect the new building. 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. Plans are in place for all staff to undertake an update on emergency management, which includes a trial evacuation, as applicable to the new building. This is being done in groups and the first group has been through the first stage of this training.</p> <p>The current fire evacuation plan has been developed by a fire safety and compliance company in consultation with the managers. This has yet to be approved by the New Zealand Fire Service.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including blankets, mobile phones, radios, batteries and a gas BBQ were sighted at the old building. There are plans to transfer these across. The water in the new building is to be heated by gas, water storage tanks are located at the rear of the complex,</p>

		<p>and emergency lighting is installed.</p> <p>Installation of the call bell system for residents requiring staff assistance was not quite completed by the day of audit. The nurse manager described how easy the new electronic system will be to extract response time reviews from.</p> <p>Appropriate security arrangements are in place and will be little different to those currently occurring. Doors and windows are to be locked at a predetermined time and entry thereafter will be via bell only. There is closed circuit television at the front entrance. The design of the facility means that entry can only be obtained from the front, unless someone is already inside the property.</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>	FA	<p>All residents' rooms and communal areas in the new facility can be ventilated appropriately. Rooms have natural light, opening external windows and the downstairs rooms have sliding doors into the internal courtyard. A sitting area in the upstairs area opens onto a balcony overlooking the internal courtyard.</p> <p>The entire new building has had underfloor heating installed. Prospective residents' rooms and communal areas can be independently thermostatically controlled.</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>	FA	<p>The service implements an infection prevention and control programme (IPC) 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 external infectious control specialists. The infection control programme and manual are reviewed annually. A copy of the infection prevention and control programme review for 2018 was sighted.</p> <p>The nurse manager is the designated infection prevention and control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the managing director who presents them to the board of directors. Minutes for the quality and risk meetings and various staff meetings included updates on infection prevention and control.</p> <p>During the influenza season, signage is placed at the main entrance to the facility requesting anyone who is, or has been unwell in the past 48 hours, not to enter the facility. A staff health policy provides guidance for staff about how long they must stay away from work if they have been unwell. It includes a list of work restrictions</p>

		for various infectious diseases. The nurse manager advised that staff may use annual leave if they run out of sick leave.
<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>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The policy provides criteria for each infection. New infections and any required management plan are discussed at handovers, to ensure early intervention occurs.</p> <p>All reported infections are documented on the relevant form and the nurse manager/infection control coordinator transfers the information onto an 'infections by month' form. The infection prevention and control coordinator reviews all reported infections, accesses appropriate advice from the local DHB infection control nurse or the public health unit as applicable, and collates, graphs and analyses the data. Any trends against data from the previous months, or the same time the previous year is analysed, possible causative factors identified and required actions implemented. Results of the surveillance programme and recommended actions and reminders of best practise are shared with staff via regular staff meetings and at staff handovers.</p> <p>A methicillin resistant staphylococcus aureus outbreak late 2018 – early 2019 has been managed according to best practices. Continuous quality improvement processes have been used to ensure the best and safest outcomes for all residents, not just those affected, and for staff.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 charge nurse of the hospital area is the restraint coordinator and ensures all staff have a sound understanding of the organisation's policies, procedures and practices in relation to restraint and enabler use. Staff spoken with were aware of the difference between a restraint and an enabler. The nurse manager has ensured staff have completed a self-learning tool on restraint and enabler use and have undertaken appropriate training in managing challenging behaviours and de-escalation/calming techniques. Records sighted showed further training is scheduled for later in 2019.</p> <p>On the day of audit, two residents were voluntarily using wheelchair lap belts as</p>

		<p>enablers. As per a key organisational objective, there has been no restraint use over the past year and the nurse manager informed that none have been used since 2014 – 2015.</p> <p>The restraint approval group meets quarterly with the last set of meeting minutes being 26 November 2018.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective actions are being identified as part of the implementation of the wider quality and risk system. Multiple examples of corrective actions needed were identified in incidents and accident reporting data, resident and family surveys and internal audits. Action plans were developed for over half of the identified corrective actions and verbal reports of actions taken were provided. However, there was limited documented evidence of some of these action plans and of the follow-up of these actions, in particular following internal audits. Hence, it was not always possible to see that the areas requiring improvement had been addressed.</p>	<p>Corrective actions are being identified in response to non-attainment of aspects of the quality and risk system, in particular internal audit requirements. However, proposed corrective actions and verification of corrective action implementation was not evident on multiple examples dating back to October 2018.</p>	<p>Corrective action plans are developed and implemented with documentation confirming the actions taken and outcomes of the actions.</p> <p>180 days</p>

<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>The Silverdale Hospital building warrant of fitness expires 1 April 2019 and the Merivale rest home building warrant of fitness expires 1 October 2019. A certificate of completion was provided for the new Somme Street facility 28 February 2018; however, neither a Code of Compliance, nor a Certificate of Public Use was available. Documentation sighted noted this was expected to occur before 1 April 2019, the date currently being planned for the move.</p> <p>Most equipment in the new building is to be new. There is recorded evidence that the items of equipment that are transferring have had electrical safety checks and/or calibration checks within the required timeframes. On the day of audit, not all equipment had been installed, or was in place in the new building and there was no evidence available that testing and tagging has occurred for items currently being installed in the new building.</p>	<p>There is not yet a Code of Compliance or Certificate of Public Use available for the new building.</p> <p>Evidence of testing and tagging for electrical equipment for the new facility was not available for the audit.</p>	<p>Verification that electrical equipment in the new facility has been tested and tagged and that the building has a Code of Compliance/Certificate of Public Use is required.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.6.3</p> <p>Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.</p>	<p>PA Low</p>	<p>A large purpose-built laundry room and rooms for storing cleaning equipment and chemicals have been constructed. Appropriate locks are on the doors. As the laundry and cleaning equipment and chemical dispensers had not been installed by the time of audit, it was not possible</p>	<p>The laundry appliances and the dispensers for cleaning chemicals are not yet installed in the new facility.</p>	<p>Evidence is required to confirm that the laundry and cleaning equipment and chemicals in the new building are safe.</p> <p>Prior to occupancy days</p>

		to affirm these designated areas were fully safe. Evidence of their safe installation is required prior to occupation.		
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	PA Low	<p>New documentation that informs of management of emergency and security situations specifically for the new building was sighted. A list of staff and the plans for training them in these processes and systems was available. Staff have been divided into groups to undertake this training and the first group have completed the first stage of this training. This process, which includes each staff being involved in a trial fire evacuation, has not yet been completed.</p>	<p>Not all staff have completed the orientation to the emergency systems and health and safety aspects of the new building.</p>	<p>Records verify that all staff working at the new Merivale Retirement Village care facility building have completed orientation to the emergency systems and health and safety aspects of the new building, including involvement in a trial evacuation.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	<p>A fire safety company has been assisting the managers with development of an evacuation plan. The final draft was available and was sighted. This has been provided to the fire service and the managers are awaiting its approval.</p>	<p>The evacuation plan has been presented to the New Zealand Fire Service, but the approval has not yet come through.</p>	<p>Evidence of fire service approval of the fire evacuation plan is required.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	PA Low	<p>A call bell system with lights in the nurses' stations and digital screens mounted in corridors has been installed. Pull bells and a button were available in each ensuite as part of the nurse call system. There</p>	<p>The call bell system has been installed but is not yet operational.</p>	<p>Evidence that the call bell system is working effectively is required prior to residents' occupation of the building.</p>

		<p>was an additional button on the wall of the room and access to a plug-in button near the bed.</p> <p>The manager informed that the system will enable easy electronic review/audit of response timeframes.</p> <p>On the day of audit, work was in progress, but the call bell system was still not operating.</p>		<p>Prior to occupancy days</p>
--	--	---	--	--------------------------------

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>The collection of quality improvement data is an integral part of the implementation of the quality and risk management system. Qualitative and quantitative data is obtained from information obtained from all aspects of the quality and risk management system, with one such source being incidents and accidents. A number of quality improvement initiatives have been pursued for various topics including infection control and food temperatures.</p> <p>In September 2018, the clinical charge nurse – hospital services, observed an increase in residents’ falls since January 2018 and developed a related quality improvement project with a goal to reduce the number occurring. Using the organisational quality improvement project plan template, four objectives were</p>	<p>Quality improvement initiatives, as a component of the quality and risk management system, are encouraged and a number of examples were underway. Of significance was a project introduced due to an increase in the number of residents falling. The planned interventions and reviews saw a reduction from 0.71 per 100 bed days of occupancy to 0.26, which has increased residents’ safety and decreased the discomfort and distress caused by falls.</p>

		<p>identified. The plan included a description of the process/method to be used, identified success measures, noted a date of completion and stated the staff responsible. Updates to the plan following reviews and evaluations were evident and actions changed accordingly. Each month, the number of falls was measured against 100 occupancies of bed days and evidence showed a reduction from 0.71 in September 2018 down to 0.26 by January 2019. The conclusion was for the strategies and measures to remain the same as the reduction has reduced distress for residents and enabled them to be safer than previously.</p>	
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>A methicillin resistant staphylococcus aureus outbreak late 2018 – early 2019 has needed management. Although management of the outbreak is continuing, this criterion has been allocated a rating of continuous improvement (CI) because of the ongoing use of continuous quality improvement processes to date. The vigilance of the charge nurse – rest home enabled her to identify the possibility of an outbreak early and appropriate advice and support was sought. Since the outbreak was confirmed, the charge nurse has documented a well-developed management plan for the outbreak, which is updated as needed. It demonstrated that actions taken have responded to the evolving situation and been implemented according to guidelines from relevant specialists. This is complemented by a documented timeline of occurrences, the actions taken, review of the outcomes achieved and notes the changes made according to findings. Specific care plans have been developed, additional advice and expertise has</p>	<p>A management plan and a timeline demonstrate that continuous quality improvement processes have been implemented in a coordinated manner to manage a methicillin resistant staphylococcus aureus outbreak. Actions have been implemented according to specialist advice, evaluations of outcomes for all aspects and at all stages have been undertaken, changes to care and support with reviews of these have occurred, and at all times, residents' needs for information and sensitivity have been upheld.</p>

		<p>been accessed, information has been provided and sensitivity to the residents' needs and emotional responses has been maintained. There is evidence of not only best practices but of coordinated continuous improvement processes having been occurring throughout the outbreak, which from the outset has targeted the best outcomes for all residents, and for staff, not just those affected.</p>	
--	--	--	--

End of the report.