

The Napier District Masonic Trust - Elmwood House and Hospital

Introduction

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

The audit has been conducted by Health Audit (NZ) 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:	The Napier District Masonic Trust
Premises audited:	Elmwood House and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 16 May 2017 End date: 16 My 2017
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	36

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

Elmwood House and Hospital is owned and operated by the Napier District Masonic Trust (NDMT). The service provides rest home dementia level care and hospital level care for up to 39 residents. There have been no changes to the facility since the last audit. The previous clinical managers have been replaced with a new clinical manager and a clinical coordinator. The service is managed by a facility manager.

This audit was conducted against the Health and Disability Service Standards and the service's contract with the district health board DHB. The audit process included the review of policies and procedures, samples of resident and staff files, observations and interviews with a resident, families, management, staff and a general practitioner (GP).

Previous areas of non-conformance have been addressed, with one new area of non-conformance identified regarding the management of controlled drugs.

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.
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Residents and family report that they are given sufficient information and feel informed. Information regarding the services available is provided and resident satisfaction surveys are conducted. Records of family contact are maintained and there is evidence that family are notified as required. The complaints process is accessible and a complaints register is maintained. There is evidence that complaints are used as an opportunity to improve services.

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.
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There is a documented and implemented quality and risk management system. The required policies and procedures are documented and current. Organisational performance is monitored. Quality activities and improvements are made in a manner which demonstrates a commitment to maintaining the safety and quality of services. Adverse events are well managed and monitored for trends. Human resource processes ensure that there are a suitable number of trained staff on duty at all times. Staff numbers are sufficient to ensure the needs of residents are met over the 24 hour period.

Continuum of service delivery

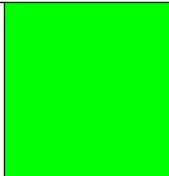
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents receive appropriate services that meet their desired goals/outcomes. Assessments and care plans are developed as required. Interventions are sufficiently detailed. Time frames for service delivery are met. Planned activities are appropriate to the needs, age and culture of the residents.

An electronic medicine management system is in place to ensure safe delivery of medications to the residents. All staff administering medications have completed a medication competencies. There are no residents who self-administer medications.

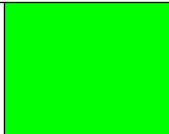
Food services meet the food safety guidelines. The individual food, fluids and nutritional needs of the residents are met. Interventions are in place when weight changes are identified.

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.
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There is a current building warrant of fitness and regular trial evacuations are conducted. There have been no changes to the facility since the last certification audit.

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.
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Policies and procedures identify the safe use of restraints and enablers. On the day of the audit there were 16 residents with a bed rail in place to maintain safety. These had been added to the restraint register and were monitored and reviewed as required. There were no residents using an enabler.

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.
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Infection control surveillance activities are appropriate to the size and scope of the service.

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	16	0	0	1	0	0
Criteria	0	36	0	0	1	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>	FA	<p>The complaints policy complies with Right 10 of the Code. Residents and their family are advised on entry to the facility of the complaint processes. The clinical manager is responsible for responding to, and managing complaints. There have been two formal complaints since the last audit. These were sampled and confirmed that they had been managed in line with policy and legislation requirements. A complaints register is documented and complaints are discussed at quality team meetings. Mandatory staff training includes the management of complaints. There have been no complaints to the Health and Disability Commissioner or the DHB since the last 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>	FA	<p>Residents and family interviewed confirmed that information is shared with them in an open manner. A review of accident/incident forms showed timely and open communication with family members as required. A family contact sheet is maintained in the residents' records and newsletters keep families informed of what is happening at the home in an ongoing manner.</p> <p>Interpreter services can be accessed from the DHB interpreter services if required. This information is also provided to families as part of the information/admission pack.</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 Napier District Masonic Trust (NDMT) commenced ownership and governance of Elmwood Home and Hospital in 2014. The NDMT also owns and operates another facility in the Napier region and continues to combine the management system. The strategic management plan and quality and risk management plan are under review with final approval scheduled for June 2017. These include goals, mission statement, values, vision and objectives defined in measurable terms.</p> <p>The service is managed by the facility manager (FM) which was a new role developed in 2015. The FM is non-clinical and has full accountability and responsibility for day to day operations since the departure of the two previous clinical managers. The departure of the two clinical managers towards the end of 2016 also resulted in a restructure of the clinical team, with a new clinical manager (CM) appointed, and the previous clinical lead now appointed as the clinical coordinator (CC). During the time of restructure and reappointment, an acting clinical manager was engaged. The new clinical manager and the clinical coordinator are both current registered nurses and commenced in March 2017. Both have previously worked in aged care and maintain current practicing certificates. There is also evidence that the FM maintains the required training and attends regional meetings related to the management of an aged care facility.</p> <p>The FM and CM C are all full-time positions and the CC is 0.6 FTE. The management team is supported by the MDMT quality and operations manager who attends all quality meetings and works across both sites. The organisational structure has been amended to reflect the changes in management and reporting lines. Management meetings are conducted, with results reported to the NDMT general manager and the board. Monthly management reports sampled confirmed that organisational performance is monitored.</p> <p>Elmwood House and Hospital is currently certified to provide 25 rest home dementia level beds and 14 hospital level beds. Twenty-three dementia level beds and 13 hospital level beds were occupied on the day of the audit.</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>FA</p>	<p>There is a documented quality and risk management system. The organisation continues to transition and review documents to provide a common management system across both sites. Relevant standards are identified and included in the policy and procedure manuals. These are accessible electronically (masters) and provided in hard copy to staff. Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. There is a system for reviewing and updating quality related documents with evidence of ongoing reviews in records of quality meeting sampled.</p> <p>A quality and risk management plan is used to guide the quality programme and includes goals and objectives. A range of quality data is gathered and used to monitor and improve services. Internal audits and satisfaction surveys are conducted in a manner that reflects improvement principles. Improvement opportunities are noted and monitored for effectiveness. All quality related data is combined and discussed at quality team meetings. It was noted that the FM, CM and CC are still learning how to fully implement this system and are supported by the NDMT quality and operations manager to do so.</p>

		<p>Organisational risks are identified and the Health and Safety Management Plan has been amended to reflect current legislation. The risk management plan covers the scope of the organisation. The organisation has chosen to maintain tertiary level compliance with the Accident Compensation Corporation (ACC) partnership programme. A hazard identification and mitigation process is implemented.</p>
<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>There is a consistent process for documenting and managing adverse events. Policy and procedures comply with essential notification reporting. Staff are documenting adverse events on an accident/incident form. These are forwarded to the clinical manager for review and closure. Corrective action plans are developed as required. The system has had some additional improvements since the last audit to gather a higher level of data for trending purposes. Policy and procedures comply with essential notification reporting for example health and safety and infection control.</p> <p>Staff confirmed they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they complete accident/incident forms for adverse events.</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>The selection and approval of new staff was previously the responsibility of the two clinical managers. Since their departure in December 2016, the responsibility has become that of the FM, with support from the CM for the selection of clinical staff. Professional qualifications are validated during the recruitment process, and annually for nurse practicing certificates. A record of reference checks and police vetting is also maintained.</p> <p>All new staff receive an orientation to the organisation and an induction to their perspective duties. This includes the essential components of service delivery and the required competencies. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority.</p> <p>The NDMT educator is currently responsible for the in-service education programme provided. In-service education is provided via core education training days that are repeated to make sure all staff receive training. All staff working in the dementia unit complete the required dementia specific training. On-going competency assessments are current for medication management, restraint and first aid certificates. The clinical manager and other RNs have the required interRAI assessments training and competencies. The educator is currently working on the development of a data base which will provide a more effective method for monitoring attendance at mandatory training.</p> <p>Staff performance is monitored as required. An appraisal schedule is in place and current staff appraisals were sighted in staff files sampled.</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>The staffing rationale policy is based on 'SNZ: HB 8163:2005 Indicators for Safe Aged-care and Dementia-Care for Consumers'.</p> <p>In both the dementia unit and the hospital the rosters evidence that sufficient cover is provided on all duties. Registered nurse cover is provided 24 hours a day, seven days a week in both areas. The dementia unit is staffed by health care assistants with the clinical coordinator available to complete assessments, care plans and reviews.</p> <p>Care staff interviewed reported that there are enough staff on duty and they were able to get through the work allocated to them. Additional staff are employed to maintain support services such as laundry, cleaning, activities and maintenance. Families interviewed reported there are enough staff on duty to provide their relative with adequate care.</p> <p>Shifts are filled in the event of staff absence. If the roster is unable to be filled by current staff, bureau staff are utilised. This was evident in the rosters sampled, particularly over a certain period when staff absence was higher than anticipated.</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>PA Moderate</p>	<p>The medicine management system is documented. Policies and procedures are aligned with guidelines and legislation. The service has commenced using an electronic medicine management system which captures the resident's allergies, indications of "as required" medications and three monthly review by the GP. Weekly and six monthly controlled drugs stocktakes are conducted. Pain assessments are evidenced when analgesia is administered.</p> <p>Medication reconciliation is conducted before/after residents were admitted to/from the hospital. A system is in place for returning unwanted or expired medications. Medicines are safely stored.</p> <p>Staff were observed administering medications in both hospital and dementia units. This confirmed compliance with the medicine administration procedure. All staff administering medications have current medication competencies. There are no residents who self-administer their medication.</p> <p>An improvement is required with regard to the documentation of controlled drugs.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual</p>	<p>FA</p>	<p>The service complies with the food safety standard and guidelines. Food services policies and procedures are in place and adhere to food safety principles and best practices. Staff working in the kitchen have current food handling certificates. Kitchen staff were observed using safe food handling practices when preparing meals. A kitchen cleaning schedule is in place and implemented.</p>

<p>food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>Residents are provided with meals that meet their food, fluids and nutritional requirements. Dietary requirement forms are completed by the registered nurses on admission and a copy is provided to the kitchen. The menu is reviewed by a dietician.</p> <p>Modified foods are provided to the residents when required. The meals are well-presented and the residents reported that they are provided with an alternative meal on request. In the event of weight loss, residents with are provided with food supplements or fortified meals as required.</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>Resident lifestyle care plans are developed by the registered nurses in line with the identified trends or issues in the interRAI assessments. Interventions for both short term and lifestyle care plans are sufficiently detailed to address the desired goals/outcomes. Documented interventions are practical and staff reported that they are easy to follow and implement. The GP confirmed that clinical interventions are effective and appropriate. Monitoring forms are in use when applicable, such as for weight, observations, wounds, behaviour and restraint. Wound assessment, monitoring and wound management plans are in place. The clinical manager and clinical coordinator has access to specialist services when needed. Multidisciplinary team reviews are conducted annually and families are invited to participate.</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>Activities provided by the service are appropriate to the needs, age and culture of the residents. Activities programmes are developed by the activities coordinator and HCA's assist with implemented. Individual activity plans are developed using the resident's recreation assessment data gathered during interview with the residents and/or their families. Activity plans reflect the resident's preferred activities and previous interests. Weekly activities are posted in the common areas. A participation log is maintained and residents with changes in participation are referred to the registered nurse for further investigation. Interviewed residents and their families reported that the activities provided are physically and mentally stimulating. Residents in the dementia unit have a 24 hour plan and are provided with less stimulating and more one-on-one and tactile activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	<p>FA</p>	<p>Resident lifestyle care plans and short term care plans are evaluated in a comprehensive and timely manner. Evaluations include the residents' degree of achievement towards meeting their desired goals/outcomes. Residents' responses to treatment regime in the short term care plans are documented. Changes in the interventions in both resident lifestyle care plans and short term care plans are evidenced when goals/outcomes are not satisfactory. Resolutions are documented in the short term care plans. The GP conducts medical reviews as required.</p>

timely manner.		
<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>	FA	There have been no changes to the facility since the last audit. There is a current building warrant of fitness.
<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>	FA	There is an approved fire evacuation plan and trial evacuations are conducted as required.
<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	The clinical coordinator is responsible for the surveillance programme. Clear definitions of surveillance and types of infections, for example facility-acquired infections, are documented to guide staff. Standardised definitions are used. Information is collated and reported at monthly quality meetings. Surveillance is appropriate for the size and nature of the services provided. Information gathered is clearly documented and an infection log maintained. Infections are investigated and appropriate plans of action were sighted. The surveillance results are discussed in the staff meeting. Both the CM and the CC are scheduled to attend an in-service training provided by the NDMT quality and operations manager to gain additional support regarding the collation and trending of infection control data, as they are both relatively new to this role.
<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 provide correct definitions of restraint and enablers. All staff receive training, and those interviewed demonstrated an understanding of what constitutes a restraint or an enabler. There are 16 hospital residents who had been assessed as requiring bed rails at the time of the audit. There were no residents using an enabler.</p> <p>Risk management plans are in place to prevent restraint-related injuries. Monitoring forms are completed for</p>

		residents with a restraint in use. The restraints are included in the resident lifestyle care plans and added to the restraint register. There were no restraint-related injuries reported.
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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 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>Medicine management information was sampled. The time of administration was not consistently documented in the controlled drug register.</p>	<p>The controlled drug register has not been consistently maintained with regard to the time of administration.</p>	<p>Document the time controlled drugs are administered in the controlled drug register.</p> <p>1 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.