

McKenzie Healthcare Limited - McKenzie HealthCare

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	McKenzie Healthcare Limited
Premises audited:	McKenzie HealthCare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 24 January 2017 End date: 25 January 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:	41

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
Yellow	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
Red	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

McKenzie HealthCare is a stand-alone company with five shareholders and company directors situated in South Canterbury. The service provides rest home, hospital and dementia level care to up to 50 residents. On the day of the audit there were 41 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents' and staff files, observations and interviews with residents, relatives, staff and management.

The service is managed by a chief operating officer/nurse manager, who has been in the role for three years. She is supported in her role by two senior nurses/CSM and a staff educator/RN. Residents, relatives and the GP interviewed, spoke positively about the service provided.

There is one area for improvement required around wound documentation.

The service is awarded a continuous improvement around improving service culture.

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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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The management team have an open-door policy. The personal privacy and values of residents are respected. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Families and friends are able to visit residents at times that meet their needs. Complaints processes are implemented, and complaints and concerns are managed and documented and learning's from complaints are shared with all staff.

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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McKenzie Healthcare has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Incidents are documented and there is immediate follow-up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

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 low risk.
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The management team takes primary responsibility for managing entry to the service with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes.

Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

There are medication policies in place that comply with current legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed.

Meals are prepared on-site. The menu is developed under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

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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The building has a current warrant of fitness and emergency evacuation plan. Ongoing and reactive maintenance issues are addressed. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is a main lounge and dining area, a library and other smaller seating areas. The internal areas can be ventilated and heated. The outdoor areas are safe and easily accessible. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

There are staff on duty with a current first aid certificate. There are emergency and disaster manuals to guide staff in managing emergencies and disasters. There is a first aider on-site at all times.

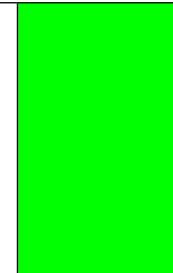
Restraint minimisation and safe practice

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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The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were two residents with a restraint (one bed rail and one lap belt) and three residents using enablers (all bed rails). Staff training has been provided around restraint minimisation and enablers and management of challenging behaviours.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since 2015.

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	49	0	1	0	0	0
Criteria	1	99	0	1	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>Information related to the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code) is made available to residents and their families. Discussions with seven care staff (four healthcare assistants (HCA), two registered nurses (RN) and the diversional therapist) confirmed their familiarity with the Code. Interviews with five residents (two hospital and three rest home) and four family members (one dementia and three hospital) confirmed the services being provided were in-line with the Code of rights. Code of rights and advocacy training is provided as a regular in-service education and last occurred in October 2017.</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 to make informed choices and give informed</p>	FA	<p>The service has policies and procedures relating to informed consent and advanced directives. All seven resident files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted, which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making.</p>

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	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. Contact numbers for advocacy services are included in the resident information pack and in advocacy pamphlets that were available at reception.
<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	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
<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	The complaints procedure is provided to resident/relatives at entry and is prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. There have been two complaints made since the last audit. Documentation, including follow-up letters and resolution, demonstrated that complaints are well managed. One of the two complaints, was made through the Health and Disability Commissioner (HDC), this was resolved in August 2017 with the HDC, confirming in a letter that no further action would be taken. Discussion with residents and relatives confirmed they were provided with information on complaints and complaints forms.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There is an information pack that includes information about the Code. The information pack is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with residents and relatives identified they were well-informed about the code of rights. Monthly resident meetings and an annual resident/family survey, provided the opportunity to raise concerns. Advocacy and code of rights information is included in the information pack and was available at reception. The service has a resident rights and advocacy policy. Large print posters of the Code and advocacy information are displayed throughout the facility.

<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>	FA	<p>The service has policies that support resident privacy and confidentiality. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms, and ensuring doors were closed while care was being undertaken. Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct is signed by staff at commencement of employment. Residents and relatives interviewed confirmed that residents were able to choose to engage in activities and access community resources. Staff education and training on abuse and neglect had been provided in December 2017.</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>	FA	<p>Discussions with staff confirmed their understanding of the different cultural needs of residents and their family/whānau. At the time of the audit there were no residents at the service who identified as Maori. The service has established links with the Maori cultural advisor for South Canterbury District Health Board (SCDHB) to review cultural policies, training and the environment. Links are established with local Marae and other community representative groups, as requested by the resident/family. Staff confirmed they were aware of the need to respond appropriately to maintain cultural safety. Cultural awareness training had been provided in November 2017.</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>	FA	<p>An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate, are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Discussions with relatives confirmed that residents' values and beliefs are considered, and that staff take into account their cultural values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial,</p>	FA	<p>The staff employment process includes the signing of house rules and a service code of conduct. Staff job descriptions include responsibilities. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy, and boundaries. Interviews with staff confirmed an awareness of professional boundaries.</p>

or other exploitation.		
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The quality programme monitored contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation, and ongoing in-service training. Policies and procedures have been reviewed two yearly. These were available in hard copy. A variety of staff meetings and residents' meetings have been conducted. Residents and relatives interviewed spoke very positively about the care and support provided.</p> <p>Staff had a sound understanding of principles of aged care and stated that they felt supported by management. Evidence-based practice is evident, promoting and encouraging good practice. The service receives support from the SCDHB which includes visits from specialists. A physiotherapist is available for six hours per week. There is a robust education and training programme for staff. The service has established links with the local Marae and other community representative groups, and encourages residents to remain independent.</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>An open disclosure policy describes ways that information is provided to residents and families. Residents and family members interviewed stated they were welcomed on entry and given time and explanation about services and procedures. Ten incident/accident forms were reviewed for the month of December 2017. There are documented monthly resident/relative meetings each month with information regarding service discussed at meetings. Management have an open-door policy. Residents and family were advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services, residents and their family/whānau. If residents or family/whānau have difficulty with written or spoken English, then interpreter services are made available.</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>	FA	<p>McKenzie Healthcare is privately owned and is governed by five shareholders and company directors. McKenzie Healthcare provides rest home, hospital and dementia level care for up to 50 residents in a 44-bed rest home and hospital wing (all dual-purpose beds) and a six-bed dementia unit. At the time of the audit there were 41 residents in total, 30 hospital level residents, including two younger persons with disabilities (YPD) residents, six rest home level residents and five dementia residents. All other residents were under the age related residential care (ARRC) contract. The facility is split into five units; Moore, Moginie, Burton, Scott and Pines (dementia care) units.</p> <p>There is a documented 2017 – 2020 strategic/business and quality plan. Organisational objectives are defined with evidence of monthly reviews and reporting to the board of directors on progress towards meeting these objectives.</p>

		<p>The service is managed by a chief operating officer/nurse manager (registered nurse), who has been in the role for three years. She is supported in her role by two senior nurses/CSM and a staff educator/RN.</p> <p>The chief operating officer/nurse manager has completed 86 hours in the past 12 months of professional development, related to managing an aged care residential facility.</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>The two senior nurses provide cover during a temporary absence of the chief operating officer/nurse manager.</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>	FA	<p>McKenzie Healthcare has an established quality and risk management system. The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Policies are current, and staff are informed of updates and changes.</p> <p>Key components of the quality management system link to the monthly team meetings and clinical/RN meetings. Monthly team meeting minutes' document that all quality outcomes and data collection is discussed. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the resident/relative satisfaction survey completed in 2016 was at 100%. There is an internal audit schedule in place and this was documented as followed. Action plans were documented where areas of non-compliance were identified.</p> <p>There are monthly accident/incident and infection reports provided for rest home, hospital and dementia level care. There is a hazard management, health and safety, and risk management programme in place. There are facility goals around health and safety. The health and safety officer (chief operating officer/nurse manager) was interviewed. She has completed specific health and safety training (level three). There is a designated health and safety committee who meet as part of the team meetings. There is a current hazard register. McKenzie Healthcare has achieved tertiary level ACC workplace safety management practice (WSMP). Falls prevention strategies are in place including intentional rounding, post falls reviews, individual interventions and the introduction of Wi-Fi mats and IPR fall sensors for frequent fallers to reduce the incidence of falls.</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>The service documents and analyses all incidents/accidents. There is a multi-use form that can be completed for all hazards, near misses and incidents and accidents. Ten resident related incident/accident forms were reviewed. Individual incident reports have been completed for each incident/accident, with immediate action noted. The data is linked to the organisation's health and safety programme trends, and individual resident risks are documented as followed up. The incident/accident forms reviewed documented immediate follow-up by a RN including completion of neurological observations for all unwitnessed falls or falls with a possible head injury. Care plan interventions and/or short-term care plans were in place where needed following a resident fall. Discussions with the chief operating officer/nurse manager, confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There had been one section 31 notification made since the last audit, relating to a medication error in December 2017.</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 policies include recruitment, selection, orientation and staff training and development. Nine staff files were reviewed (two senior nurses, two RN, three HCAs, one housekeeper and one diversional therapist). All files included appropriate employment documentation and up-to-date performance appraisals. A register of practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice, including caring for those with dementia. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>An annual education schedule for 2018 is being implemented. Additional training is provided as needed. Registered nurses (RNs) are provided with RN specific training (such as NikiT for example). A competency programme is in place with different requirements according to work type. There are 14 HCAs including those that work in the dementia unit. All 14 dementia unit staff have completed the required dementia standards. The service does not allow staff to work in the dementia unit until they have completed the training. All registered nurses have an up-to-date first aid certificate. Seven of nine RNs are trained in interRAI.</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</p>	FA	<p>An organisational staffing policy aligns with contractual requirements and includes skill mixes. The chief operating officer/nurse manager works 40 hours per week and shares the 24/7 on-call duties with the senior nurses. There are at least two RNs on duty for the morning and afternoon shifts and one on the night shift. The facility is split into five units; Moore, Moginie, Burton, Scott and Pines (dementia care) units.</p> <p>In Moore (five hospital residents) and Moginie (11 hospital residents) units, there is one RN on duty in the morning shift and afternoon shift, and night shift. They are supported by three HCAs on the morning shift,</p>

<p>providers.</p>		<p>two HCAs on the afternoon shift and one HCA on the night shift.</p> <p>In Burton (eight hospital and two rest home residents) and Scott (six hospital and four rest home residents), there is one RN on duty in the morning shift and afternoon shift, and night shift. They are supported by four HCAs on the morning shift, three HCAs on the afternoon shift and one HCA on the night shift.</p> <p>In Pines (five dementia residents), there is one HCA on duty in the morning shift and afternoon shift, and night shift. The RNs from Moore and Moginie units cover the Pines dementia care unit. Interviews with relatives and residents all confirmed that staffing numbers were appropriate. Healthcare assistants interviewed stated that they have sufficient staffing levels.</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>The resident files were appropriate to the service type. Residents entering the service had all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are located in the nurse's station. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Record entries were legible, dated and signed by the relevant staff member.</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 identified.</p>	<p>FA</p>	<p>The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. Dementia specific information is also provided. The service screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. Seven signed admission agreements were sighted. The admission agreement form in use aligns with contractual requirements.</p>
<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>	<p>FA</p>	<p>The service has a transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and 'the yellow envelope' is used. The RNs report that they include copies of all the required information in the envelope.</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>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. The service uses a medication software programme. All residents have individual medication orders with photo identification and allergy status documented. The service uses a four-weekly blister pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Short-life medications (i.e., eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurses and senior healthcare assistants with medication administration responsibilities. Fourteen medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. No residents self-administer medicines; however, a policy is in place as needed.</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>There is a fully equipped commercial kitchen for the facility that was observed to be organised and very clean. The chef advised that most food is locally sourced, and all food is prepared and cooked on-site. All kitchen staff have completed food safety training. The menu has been approved by a dietitian and a food safety plan has been approved March 2017. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. Meals were provided in three dining rooms and transported in hotboxes. Hot food temperatures were taken at each meal service and these were recorded. There were sandwiches and snacks available for residents outside of meal times. Special eating aids are provided as assessed to promote independence. A tray service is available if required by residents.</p> <p>Kitchen waste is collected by commercial operators. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents' dietary needs are communicated to the kitchen staff. Special diets can be catered for. Alternative meals can be accommodated if needed. Residents' weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the</p>	<p>FA</p>	<p>The reason for declining service entry to prospective residents to the service is recorded. Should this occur, it would be communicated to the potential resident/family/EPOA and the appropriate referrer. Potential residents would only be declined if there were no beds available or if they could not meet the service requirements.</p>

immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All seven files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. All seven files sampled, contained appropriate assessment tools that were completed and in long-term files, assessments that were reviewed at least six monthly or when there was a change to a resident's health condition. The interRAI assessment tool is implemented. Seven of the nine registered nurses are interRAI trained and the enrolled nurse is currently undertaking interRAI training. InterRAI assessments have been completed for all long-term residents.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Registered nurses are responsible for developing resident care plans. The care plans reviewed (two dementia, three hospital including a younger person disabled and two rest home residents), described the support required to meet the resident's goals and needs and identified allied health involvement. The care plans reviewed were resident focused. The interRAI assessment process informs the development of the resident's care plan. Residents and their family interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status (link to 1.3.6.1 for short-term care plans and wound care plans).
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. Care plans reviewed reflected the required health monitoring interventions for individual residents. Wound assessments, treatment and evaluations were in place for seven residents with wounds (none in dementia care). These included four skin tears, one stage two pressure injury, one cyst and one shingles. Wound assessments, management plan and evaluations were in place for all wounds and wounds had been dressed and evaluated according to set timeframes. Wound care plans were not reflected into the long-term care plans (or a short-term care plan). Registered nurses interviewed could describe access to wound specialist nurses if required. The GP reviews wounds three monthly or earlier if there are signs of infection or non-healing.

		<p>Continence products are available and resident files included urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</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 service employs three activity staff (one a diversional therapist and two diversional therapists in training) who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities for five days per week with activities staff. Planned weekend activities are delivered by the healthcare assistants. The group activities programme is developed monthly, and a copy of the programme is available in the lounge and on noticeboards. The group programme includes residents being involved within the community with social clubs, churches and school. Exercises are provided three times a week. There is a separate programme for the dementia unit. The DT advised that this is a very flexible programme depending on the residents on a day-to-day basis. The service provides activities for younger residents such as music, computers, the bowling club and films.</p> <p>Group activities are provided in the large communal dining room, in seating areas and outdoors in the gardens when weather permits. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance. Individual activities are provided in residents' rooms or wherever applicable.</p> <p>On the days of the audit, residents were observed being actively involved with a variety of activities.</p> <p>Newly admitted residents are interviewed on or soon after admission and a social history is noted. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p> <p>The service has its own van for transportation. The DT drives the van and has a current first aid certificate. Residents interviewed described weekly van outings, musical entertainment and attendance at a variety of community events.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term nursing care plan has been evaluated at least six-monthly or earlier where there was a change in health status. There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as</p>

<p>manner.</p>		<p>sighted in resident files sampled.</p> <p>Multidisciplinary meetings were documented six monthly along with the interRAI. Long-term care plans were then evaluated and rewritten. There was documented evidence that care plan evaluations were current in resident files sampled. The registered nurses interviewed explained the communication process with the GP.</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 disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents and/or their family are involved as appropriate when a referral to another service occurs. Registered nurses interviewed described the referral process should they require assistance.</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>There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility, including the dementia unit. Safety datasheets were available.</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</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 1 July 2018. The maintenance person addresses daily maintenance requests. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment and functional testing of electric beds and hoists. Hot water temperatures in resident areas are monitored and stable between 43-45 degrees Celsius. Contractors are available for essential services. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. The service employs grounds and garden staff that maintain the external areas.</p>

purpose.		Residents were able to access the outdoor gardens and courtyards safely. Seating and shade is provided. The outdoor designated smoking area closed 1st January 2018 to become completely smoke free. Staff interviewed state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. The dementia unit has an accessible and secure outdoor garden.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All bedrooms in the rest home/hospital and dementia unit have either a shared ensuite or close/easy access to communal toilets. There were communal toilets located close to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares. The bathrooms are large enough for mobility aids to be safely used.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All residents' rooms were single and of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites and bathrooms. Residents are encouraged to personalise their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are lounges and dining areas in both the dementia units and hospital and rest home areas. There are seating alcoves available for quiet private time or for visitors. The communal areas were easily and safely accessible for residents.
Standard 1.4.6: Cleaning And	FA	The facility has documented systems for monitoring the effectiveness and compliance with the service

<p>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>policies and procedures. Laundry and cleaning audits were completed as per the internal audit programme. The laundry has an entry and exit door with defined clean/dirty areas. The service has a secure area for the storage of cleaning and laundry chemicals for the laundry.</p> <p>There are dedicated cleaning and laundry persons on duty each day. Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing was treated with care and returned to them in a timely manner.</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>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergency management, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift and accompanying residents on outings. McKenzie HealthCare has an approved fire evacuation plan, letter dated 15 November 2004. Fire evacuation drills occur six monthly, with the last drill occurring on 5 September 2017.</p> <p>Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (BBQ) available in the event of a power failure. There is a back-up generator and diesel fuel supplies to run this, the heating is diesel fuelled and can continue in a power outage. There are civil defence kits in the facility and sufficient stored water (25,000 litres). Call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. The facility is secured 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>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service</p>	FA	<p>McKenzie Healthcare has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A senior nurse (RN) is the designated infection control nurse. The monthly team meeting is the infection control team. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation and as part of the annual training programme.</p>

providers, and visitors. This shall be appropriate to the size and scope of the service.		
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>Resources are in place to implement the infection control programme at McKenzie HealthCare. The infection control (IC) nurse maintains her practice by attending infection control updates. The infection control coordinator reports to the monthly facility meetings. External resources and support were available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities were available throughout the facility and alcohol hand gel is freely available.</p>
<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 control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies have been reviewed and updated at least two yearly by the management team. The IC programme has links to Bug Control information.</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>The facility is committed to the ongoing education of staff and residents. This is facilitated by the infection control nurse with support from the nurse manager. All infection control training is documented, and a record of attendance is maintained. Additional training has included chickenpox for both staff and family members after a family member contracted the disease and also correct handling of cytotoxic medications following an outpatient's appointment for one of the residents and their subsequent prescription of cytotoxic medications.</p> <p>Visitors were advised of any outbreaks of infection and advised not to attend until the outbreak had been</p>

		resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. There have been no outbreaks since 2015. Education around infection prevention and control had been provided in 2017.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly facility infection summary and staff are informed. This data is monitored and evaluated three monthly and annually.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated and justified, and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were two residents with a restraint (one bed rail and one lap belt) and three residents using enablers (all bed rails). The three files for the residents using enablers reflects a restraint/enabler assessment and voluntary consent by the resident. Staff training has been provided around restraint minimisation and enablers in October 2017 and management of challenging behaviours in May 2017.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (senior nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.
Standard 2.2.2: Assessment	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved

<p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's care plan. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in two resident files where restraint was in use. Restraint use is discussed in the clinical/RN meetings. This was confirmed in the meeting minutes.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in two resident files where restraint was in use. Restraint use is discussed in the clinical/RN meetings. This was confirmed in the meeting minutes.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint minimisation programme is discussed and reviewed at the RN meetings and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.</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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	All wounds identified had an in-depth wound care plan in place. Caregivers and RNs interviewed were aware of residents with specific skin care needs. Care plans did not reflect current wounds.	The six wounds (non-pressure injuries) did not have a short-term care plan in place and/or were not linked to the long-term care plans.	<p>Ensure that wounds have a short-term care plan in place or are reflected into the long-term care plan.</p> <p>60 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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service provides services that are individualised and focus on dignity and respect. Following a recent community issue involving different Iwi and also staff surveys indicating poor communication, the service was keen to ensure that McKenzie Healthcare continued to be a safe place to work, and worked to improve the service culture and care and exceed the required standard.</p>	<p>Over late 2016 and 2017 an issue arose in the local community and a staff member’s death that affected many staff. The issue affected staff who identified from different Iwi and families. The service worked to ensure that issues affecting the community did not adversely affect the culture within the service and that resident care would remain the highest priority for all staff. A survey undertaken also indicated that staff felt they lacked communications.</p> <p>The service linked with a local Kaumātua who was also the Māori and Pacific Island adviser for the area and a restorative justice officer. The management team and the adviser wanted to ensure that the staff worked within a safe and supported environment. They considered the strengths of the staff and service and how to support these and also to build resilience for the staff (and thereby the community).</p> <p>The framework ‘Improving Joy in work’ was implemented and</p>

			<p>communicated through staff meetings and individual staff meetings. Following feedback from staff, each staff member has a documented preferred mode of communication and all information is provided to individuals in their preferred way.</p> <p>The service has contracted a counselling service for staff. This service provided three free sessions to assist staff to move forward (following the community incident or any other issues).</p> <p>The outcome has been that community issues have not affected the care in the service. Staff have been supported to work with each other and the management team to help and support each other. Staff interviewed all commented on the supportive and caring team they work with.</p> <p>Resident care has remained of a high standard, with recent compliments (three) praising the staff of respect, love and team work. Residents also reported on interview that the staff are a great team and supportive, recent resident meetings document that they no longer require a representative to speak for them as they feel safe and supported to talk for themselves</p>
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End of the report.