

Metlifecare Limited - Powley

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Metlifecare Limited
Premises audited:	Metlifecare Powley
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 April 2018 End date: 19 April 2018
Proposed changes to current services (if any):	The service wishes to have medical (non-acute) services added.
Total beds occupied across all premises included in the audit on the first day of the audit:	45

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

Metlifecare Powley provides rest home and hospital level care for up to 45 residents. The service is operated by Metlifecare Limited and managed by a nurse manager for the care unit and a village manager for the village. The village is not included in this audit as no residents are under a District Health Board contract. The nurse manager oversees all clinical services and is supported by a team of registered nurses including a nominated senior registered nurse. Residents and families spoke positively about the care provided.

Metlifecare Powley would like to have medical (non-acute) services as part of their services. Services reviewed during this audit showed that all requirements are met for this to occur.

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

This audit has resulted in a continuous improvement in three criteria, two areas related to quality and risk management and one related to emergency management. No areas requiring improvements were found.

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 their families are provided with information about the Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) and these are respected. Services and care provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. There was no evidence of abuse, neglect or discrimination.

Open communication between staff, residents and families is promoted and encouraged and confirmed to be to be effective. Interpreting services are available if required. Residents and families are provided with the information they need to make informed choices and to give consent and staff act on any advance directives.

Currently no residents or staff identify as Maori. The model of care meets the needs of residents in a manner that acknowledges and respects the individual cultural values and beliefs of Maori and all other cultures. Residents of many cultures interviewed reported that their individual values and beliefs are respected.

The service has linkages with the community and has a range of specialist healthcare providers to support best practice and meet resident`s needs.

A complaints register is maintained with complaints resolved promptly and effectively. Three recent complaints of a minor nature remained open at the time of audit, but documentation shows these have been addressed within required timeframes.

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

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents` information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant records are maintained in using an integrated record system. Archived records can be retrieved if and when necessary.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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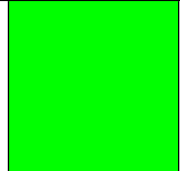
Entry to services is clearly defined in policies. If a potential resident is declined entry to the service this is recorded and the referrer informed.

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring hospital and rest home level care. Staff are qualified to perform their roles and deliver all aspects of service delivery. The nurse manager, senior registered nurse and registered nurses oversee the care and management of residents along with a team of staff. All residents are assessed on admission and assessment details are retained in the individual resident's record. The multidisciplinary team and external providers have input into the residents' care and support to promote continuity of care.

The service has implemented a web-based medication management system that complies with current legislation. Staff who assist in medication management are assessed as competent to perform their role. There is a process in place for residents to safely self-administer their medications.

The menu plans have been reviewed by a dietitian. Each individual resident is assessed on admission for any identified need in relation to nutritional status, weight, likes and dislikes and any cultural needs are identified. The kitchen has a registered food safety plan that complies with current food safety legislation and guidelines are in place.

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 facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical and clinical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

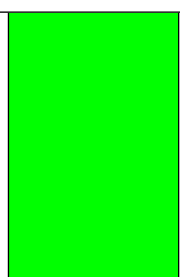
Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support a restraint free environment. No enablers or restraints were in use at the time of audit. Policy and staff education cover the use of a comprehensive assessment, approval and monitoring process with regular reviews required should restraint be put in place. Policy states the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually. Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reviewed reflect current accepted good practice and were readily available to staff.

Infection prevention and control reference material and education packages can be accessed. Education provided by the infection control nurse and other health professionals is relevant to the service setting.

Specialist input is sought if required from the general practitioner, laboratory microbiologist and other infectious disease specialists. The type of surveillance undertaken is appropriate to the size of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	3	89	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers` Rights (the Code). The Code is included in staff orientation and in the in-service and online education programmes. Resident`s rights are upheld by staff (eg, staff knocking on residents` doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents reported that they understand their rights. The family reported that relatives are treated with respect and dignity.</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</p>	FA	<p>Evidence was seen of the informed consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification purposes, sharing information with an identified next of kin and/or for the general care and treatment. The resident`s right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring where applicable this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. An advance directive and advance care</p>

<p>informed consent.</p>		<p>plan are used to enable residents to choose and make decisions related to end of life. The records reviewed had had signed advance directives that identify residents' wishes and meet legislative requirements.</p> <p>Residents and family (where appropriate) are included in care decisions.</p>
<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>	<p>FA</p>	<p>Advocacy information is available in brochure format at the entrance to the facility. Residents and family are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service and/or Aged Concern is undertaken annually as part of the in-service education programme. The staff interviewed reported knowledge of residents' rights and advocacy services. The contact number for the resident advocate is documented on the wall outside the nurse manager's office.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents interviewed reported they are supported to be able to remain in contact with the community through outings and walks. A walking chain has been implemented and is proving to be successful. Policy includes procedures to be undertaken to assist residents to access community services. The activities programme involves linking with other aged care providers and support services for events.</p> <p>Visitors are welcome and encouraged to visit anytime. Hours are flexible. Residents can have visitors of their choice.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that seven complaints have been received over the past year and that four complaints have actions taken, through to an agreed resolution. Three recently received complaints have documented timeframe showing each complaint has been investigated and communication has occurred from the nurse manager to the person who wrote the complaint. The facility is waiting for confirmation that a resolution has been agreed.</p> <p>Corrective action plans show any required follow up and improvements have been made where possible. For example, one complaint related to the type of diet a resident received. Resident dietary needs are documented daily, on a paper form so staff serving the evening meal know resident's requirements. Investigation found that the dietary instruction paper was not available for this day's meal service; it may have fallen to the floor. Follow up included staff education and each resident's dietary requirements for the evening meal being laminated. A post corrective action review identified no further incorrect diets had</p>

		<p>been given to residents.</p> <p>The nurse manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. A copy of the Code and other information related to rights are in the residents` rooms and displayed throughout the service. The comprehensive information packs were sighted and contained all relevant information on the Code and pamphlets. Opportunities for discussion and clarification relating to the Code are provided to residents and their families as confirmed by interview with the clinical staff. Discussions relating to residents` rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident in their own room). Residents and family reported that the residents are addressed in a respectful manner that upholds their rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of resident related information. The residents interviewed, and records reviewed evidenced that the individual values and beliefs of the residents are respected.</p> <p>There were no concerns expressed by the residents and family about abuse and neglect. Staff interviewed reported knowledge of residents` rights and understand dignity, respect and what to do if they suspect a resident was at risk of abuse or neglect.</p> <p>The Privacy Officer for this service is the nurse manager. The independent advocate from Aged Concern is named and the contact number is displayed near the nurse manager`s office.</p> <p>Maintaining residents` independence is encouraged by all staff and was noted on the residents` care plans reviewed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and</p>	FA	<p>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi and a family approach is included.</p> <p>Family/whanau input and involvement in service delivery and decision making is sought as required. The in-service education programme includes cultural safety. Staff demonstrated an understanding of</p>

<p>disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>meeting the needs of residents who identify as Maori and the importance of whanau. The staff and management interviewed reported there are no known barriers to Maori accessing the service. There were no residents that identified as Maori and/or no Maori staff at the time of the audit. The local Marae is Hoana Waititi Marae and the contact number was available and displayed for staff to access if required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The cultural and/or spiritual needs of the resident are provided for in consultation with the resident and family as part of the admission process and ongoing assessment. Specific health issues and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the resident's individual values and beliefs. If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family reported that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have completed the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidenced based policies, input from external specialist services and allied health professionals. The service has access and support from visiting DHB gerontology nurse specialists, educators, palliative services and mental health services for older persons, dietitians, the wound care nurse specialist and other health professionals as required on a referral basis. The general practitioner (GP) visits regularly and was interviewed. The GP confirmed the service sought prompt and appropriate medical intervention when required and the staff were responsive to medical requests.</p> <p>Residents and family satisfaction surveys evidenced overall satisfaction with the quality of care and the services provided.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. One registered nurse has signed up with the ADHB to be part of the professional development and recognition programme (PDRP). This offer is a</p>

		recent development from the DHB and other registered nurses are still considering the options made available for ongoing professional development.
<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 members stated they were kept well informed about any changes to their/ their relative`s health status and were advised in a timely manner about any incidents or accidents and outcomes of regular or urgent medical reviews. This was supported in residents` records reviewed. Staff understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services through the ADHB although reported this was rarely required. Staff employed represent many different nationalities as do the residents and many languages are spoken. There are communication strategies in place for residents with cognitive impairment or who have non-verbal means of communication.</p> <p>The registered nurses use a communication book which is updated to ensure residents who have up and coming appointments have appropriate transportation arranged prior to the appointment. This communication book sighted is also used for visiting health professionals should an appointment be arranged to visit or assess a resident.</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>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of quarterly reports to the board of directors/owners showed adequate information to monitor performance is reported including financial performance, complaints, satisfaction survey results, occupancy, emerging risks and issues. Metlifecare Powley have a business plan which reflects the organisation`s goals and the quarterly report shows how these are being met.</p> <p>The service is managed by a registered nurse manager who holds relevant qualifications and has been in the role for 10 years, five years at a sister site and five years at the Metlifecare Powley. Responsibilities and accountabilities are defined in a job description and individual employment agreement. She is supported by a team of registered nurses and the village manager.</p> <p>The nurse manager and clinical quality and risk manager representing Metlifecare confirmed their knowledge of the sector, regulatory and reporting requirements. The nurse manager maintains currency through ongoing education, regular management conferences and quarterly clinical cluster group meetings.</p>

		The service holds an Age Related Residential Care contract with Auckland District Health Board which all 45 residents were receiving services under at the time of audit. At the time of audit there are seven rest home and 38 hospital level residents.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the nurse manager is absent, the nominated senior registered nurse carries out all the required duties under delegated authority and with assistance from the clinical quality and risk manager. During absences of key clinical staff, the clinical management is overseen by nurse manager who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, wounds and falls. The documentation and systems implemented show that key components of service delivery are explicitly linked to the business management decisions at senior management level and board level.</p> <p>Meeting minutes from registered nurse meetings, staff meetings and clinical management team meetings were reviewed and confirmed regular review and analysis of quality indicators and that related information is reported and discussed. Staff reported their involvement in quality and risk management activities through audit activities, discussions at staff handovers, and implementation of corrective actions. Sharing of all quality information is undertaken to a high standard. Relevant corrective actions are developed and implemented to address any shortfalls. This was confirmed in documentation sighted for clinical and non-clinical areas.</p> <p>Corrective actions are only signed off once they have been evaluated and the outcomes have been documented. Some corrective actions have led to the implementation of projects, such as the falls risk management project. The outcome and benefits gained by this ongoing project show that the resident walking group, which was established as part of the project, makes this a fun activity for residents. This group was observed both days of audit. Staff own the risk of falls and are much more aware of actions to be taken as part of their everyday routine to prevent falls. One unique correction noted is that a picture of a tree is placed at the head of the bed for residents who are high falls risks. The bottom of the tree indicates the correct height of the bed for residents' to safely get out of bed, according to physiotherapist instructions. The corrective action which led to this project was generated in September 2017 when the</p>

		<p>falls rate increased to 18. Data is available for all following months and in February 2018 the rate was down to 6 falls which meets the Metlifecare target of no more than 6.4 falls per month.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey (2017) showed that Metlifecare Powley gained an 88% overall satisfaction rating. The opportunities for improvement identified related to areas which scored below 85% satisfaction. Some examples of improvements made to address the issues raised are that GP services have been contracted to a new provider and residents are given a choice of menu for all meals. The kitchen manager attends part of all resident meetings to answer any queries of concerns from residents. The success of the improvements will be measured in the upcoming 2018 resident and family satisfaction survey results.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Updated or new policies are presented at staff meetings and staff sign to say they have read and understand the policy.</p> <p>The nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Monthly environmental audits are undertaken and this includes emergency management supplies and equipment. Each area of the facility such as kitchen, clinical and offices have individualised risk registers and this information is displayed publicly on notice boards. All registers are reviewed monthly by the health and safety committee and fully updated at least annually.</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>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the clinical quality and risk manager electronically and trending is completed. Adverse event data is monitored at the quarterly clinical management team meetings at organisational level.</p> <p>The nurse manager and clinical quality and risk manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification, using a section 31 form, of a significant event made to the Ministry of Health. This relates to a power outage in April 2018. (Documentation sighted). This is the only notification made since the previous audit. There have been no police investigations, coroner's inquests, or issues-based audits.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB.</p> <p>There are four trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels shown on rosters match the required staffing skills as shown on the interRAI level of care report. The facility adjusts staffing levels to meet the changing needs of residents. Evidence of this is shown during a power outage when two extra staff members worked on all shifts. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>There are dedicated kitchen, gardening and maintenance staff who report to the village manager. Dedicated laundry and cleaning staff report to the nurse manager. An administrator works 9 am to 2.30 pm three days a week and the activities coordinator works Monday to Friday 9 am to 3.30 pm.</p> <p>The nurse manager works Monday to Friday and is on call.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All staff hold current first aid certificates. There is 24/7 RN coverage at the facility.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was completed in the residents' records sampled for review. Clinical notes were current and integrated with the general practitioner records, and allied health provider notes. This includes interRAI assessment information entered into the</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>electronic database. Recent records sampled were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely and are readily retrievable. Residents` records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. The current records are locked in a cupboard in a locked room.</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>	FA	<p>The admission policy includes the procedure to be followed when a resident is admitted to the home. The Metlifecare admission agreement contains all required information and all agreements reviewed were signed and dated by two parties the resident and/or representative and the organisation representative. Entry screening processes are documented and communicated to the resident and their family to ensure the service can meet the needs of the resident. The resident and family reported the admission agreement was discussed with them prior to admission and all aspects were understood. Needs assessments were completed prior to entry by the DHB needs assessment co-ordination service (NASC) and the care level determined. A copy of the level of care was in each individual resident`s record sighted.</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>	FA	<p>All residents` exit, discharge or transfer is documented using specific forms. The service utilises the transfer of care from residential care to the ADHB and this was confirmed in records reviewed. The yellow bag system is implemented and works effectively as explained by the senior registered nurse. Any known risks are identified to the place of transfer to manage the residents safely. Expressed concerns of the resident and family are clearly documented including advance directives and EPOA documentation. This was confirmed in residents` records reviewed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. This care guide also includes provision of medication management for residents who have hospital non-acute medical conditions. The guidelines ensure any legislative requirements and safe practice guidelines can be followed efficiently by the registered nurses who are responsible for medication management at this facility. A staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted local pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by</p>

		<p>dates. Clinical pharmacist input is provided on request.</p> <p>The records of temperatures for the medication fridge and the medication room reviewed were within the recommended range.</p> <p>The medications are prescribed through the web-based system for electronic prescribing practices which includes the update of any changed medications, the date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The GP completes the three-monthly reviews and this is recorded on the electronic records sighted.</p> <p>There are four residents in the facility who self-administer medications at the time of the audit. Appropriate processes were in place to ensure this is managed in a safe manner. The residents concerned use 'puffers' and nasal spray only.</p> <p>There is an implemented process for analysis of any medication errors with internal audits evidencing the reduction in medication errors since the introduction of the web-based medication management system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Policies and procedures implemented cover all aspects of food preparation. Documentation identifies that safe food hygiene management practices are followed.</p> <p>The menu has been reviewed by a registered dietitian, 21 March 2018, as being suitable for the residents living in a long-term care facility. The kitchen has dietary information for all residents and their likes and dislikes are catered for. Residents are routinely weighed at least monthly and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these met. The residents and family/whanau reported being overall satisfied with the meals and fluids provided including catering for their individual preferences.</p> <p>Food, fridge and freezer temperature recordings are undertaken daily and meet requirements. The service has a registered food safety plan - food safety grade A and are awaiting a planned re-audit. All staff in the kitchen have completed appropriate food safety training.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given adequate time to eat their meal in an unhurried manner and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy the local Needs Assessment and Service Co-ordination Service (NASC) is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p>

<p>service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>If the needs of a resident change and they are no longer suitable for the service offered a referral for reassessment is sent to the NASC and a new placement found in consultation with the resident and family. Management reported they refer residents to different levels/types of care services, if they are unable to support the resident (such as hospital psychogeriatric level care) or if a secure dementia care service is more appropriate.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial assessment which includes assessment of the residents' health and personal needs is completed on the day of admission. The registered nurses utilise standardised risk assessment tools for the initial and ongoing assessments. The interRAI along with other paper-based assessments, information gained from the resident and their family, referral information, observations and examinations carried out are used as the basis for developing the long-term care plan. There were specific assessment tools and management plans for behaviours that challenge and end of life care. The residents and family members interviewed expressed satisfaction with the support provided and confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>In all records sampled, evidence was sighted of interventions related to the desired outcomes. Risks identified on admission are included in the long term care plan and these included falls risk, pressure area risk and pain management. The assessment outcomes from the interRAI assessment process were included to update the care plan. The care plans are discussed with staff at handover if changes are made.</p> <p>All health professionals documented in the resident's individual clinical record and have access to care plans and progress notes as part of the integrated record system. Documentation in records reviewed included nursing notes, medical reviews and hospital or referral correspondence. The residents reported that they are included in the care planning and are aware of any changes and these are discussed with them. Care staff reported they are informed of any changes to care plans at shift handover. The residents reported satisfaction with care provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs</p>	<p>FA</p>	<p>Documentation, observation and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individual needs was evident in all areas of service provision. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available suited to the levels of care provided and in accordance with the residents' needs. For hospital non-acute medical residents admitted to this service adequate interventions would be developed and implemented</p>

and desired outcomes.		by the registered nurses interviewed to meet their needs and desired outcomes. Staff have received adequate education and practical skills to manage non-acute medical residents and the requirements of certification.
<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>	FA	<p>Metlifecare Powley has a monthly programme which is displayed weekly. The programme is based on activities that are meaningful for residents. Family and community activities are planned and facilitated by an activities coordinator who is currently training towards the Careerforce New Zealand apprenticeship in social and community services and when completed will be a registered diversional therapist. The activities coordinator was previously a caregiver before taking over this role. Outings in the community are arranged in the facility van. There is no hoist in the van, so if needed, a total mobility service would have to be contracted. A mobile community library bus visits and there is a library in the facility that residents can access.</p> <p>A social assessment and history is undertaken on admission to ascertain residents` needs, interest, abilities and social requirements. The resident`s recreational needs are evaluated initially at one month after admission and three monthly thereafter. The care plan is updated if any changes occur. Family are welcome to participate.</p> <p>Activities reflect resident`s individual goals, ordinary patterns of life and include normal community activities, individual and group activities with regular events being offered. Residents and families are involved in evaluating and improving the programme through monthly residents` meetings and/or satisfaction surveys. Residents interviewed confirmed they find the programme interesting and fun.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluations are conducted at least six monthly and recorded on the care plan. The service has processes in place to use the interRAI assessment and other evaluations to update the care plan. Care evaluations are conducted for all residents` needs and progress towards meeting the goals that have been previously set is recorded.</p> <p>When there are changes in the resident`s needs the service changes the long term care plan to capture this. The long term care plans identify the need, interventions and evaluation of the interventions. There are also additional short term plans, such as wound treatment, falls and fall minimisation plans, which capture any short term changes. Wounds are evaluated at each dressing change and as required or determined by the clinical team. If the issue then becomes a long term need, these are then recorded and updated on the long term care plan. Changes are discussed with care staff at handover between shifts, as observed, or though the communication book system for both caregivers and registered nurses.</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>	FA	<p>Residents are supported to access or seek referral to other health professionals and/or disability service providers. Although the service has a 'resident GP' residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested the GP sends a referral to seek specialist input. Copies of referrals were sighted in residents' records, including to radiology, health screening and medical and/or surgical specialists. There are several specialists/health providers that also conduct visits to Metlifecare Powley if required. The resident and the family are kept well informed of the referral process as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>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>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff who handle chemicals have completed safe chemical handling education and training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 22 June 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment (July 2017) and calibration of bio medical equipment (March 2018) is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment is hazard free, residents are safe and independence is promoted. Monthly internal environmental audits are maintained with corrective action follow up being undertaken if required.</p> <p>Equipment sighted includes hi-low beds, electric hospital beds, a Nikki pain pump, oxygen concentrators, four standing hoists, one sling hoist, appropriate bathroom and toilet chairs and equipment. The corridors are wide with secure handrails and all bedroom doors allow a bed to be moved from the room. There is a chapel which is used by family and residents as they wish. Family are able to stay overnight with relatives if required. Single occupancy bedrooms ensure residents' privacy. These items are available to address the needs of medical residents as required.</p>

		<p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents and family members confirmed that repairs and maintenance is undertaken promptly as required and that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes toilet and hand basin ensembles in every bedroom. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. These items would meet the needs of medical residents.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. The bedrooms are large enough for lifting equipment to be used if required. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>The door widths throughout the facility, including all resident bedrooms is adequate to move beds and accommodate lifting equipment. All bedrooms would be suitable for medical residents.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. The dining area has limited space but the nurse manager stated that not all residents use the dining area, some resident choose to eat in their bedrooms. The size of the dining room has never been an issue for the service and the number of beds will not change if they are granted medical status.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry. One family member interviewed stated they do their relatives laundry as a personal preference not because they have had any issues with the laundry service. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>During a recent power outage at the facility, laundry was undertaken by the Powley laundry staff at a sister facility. Staff reported that this system worked very well.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Safety data sheets are kept in the laundry along with daily task lists.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and by the chemical provider undertaking monthly checks of the chemical usage in the washing machines.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 01 June 2000 and there have no changes to the building footprint since this time. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 08 February 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Emergency procedures were followed during a power outage from the 11 April 2018 to the 15 April 2018 and the service managed to a very high level of functioning with the only day to day tasks not fully completed being showering and being able to follow the set menu. This has gained a continuous improvement rating.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 45 residents. Water storage tanks are located in the grounds of the complex (4000 litres), and there is a diesel generator on site. A smaller generator was purchased during the power outage to run cell phones and the electronic tablets used for medication management. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and an off-site security company checks the premises three times each 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>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by electric powered water radiators and heat pumps. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>There is a designated infection prevention and control nurse who is the senior registered nurse for this facility. The infection control nurse has a job description that outlines the responsibilities for managing and implementing the programme. The infection prevention and control programme reviewed annually aims to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual reviewed. The organisation is a member of an externally contracted service which provides reference and educational material for staff and guidelines for all pandemic situations and/or management of all types of infections.</p> <p>There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise family/whanau not to visit if they are unwell. There are sanitising antibacterial gel dispensers located throughout the facility for staff, visitors and residents to use. Staff demonstrated good knowledge and application of infection prevention and control principles.</p>
<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>The infection control nurse and registered nurses implement the infection control programme with support from all staff. Advice can be sought from the general practitioners, the laboratory microbiologist and the infection prevention and control team at the DHB if and when necessary. Staff from all areas of service delivery are represented on the infection prevention and control committee. Infection control matters are discussed at the three monthly staff meetings. Minutes of meetings are maintained. The infection control nurse has access to residents' records and diagnostic results. Shift handover is a forum to discuss and update on results of tests and/or any infections with the care staff.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention</p>	FA	<p>The infection prevention and control policies and procedures have been developed by the organisation and reflect current accepted good practice. The service has access to good practice resources and flip charts are available in the nurses' office for staff use as reference material. The policies are appropriate to the services offered by the facility and are reviewed as required.</p>

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.		Staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions per the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control nurse provides education for all staff. There are online learning modules that are part of the mandatory education programme on infection prevention and control. The infection control nurse has completed training at the DHB on infection control topics. All training was recorded in the staff records reviewed by the senior nurse/ICN. One on one education is provided to residents at every opportunity.
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	The service uses standardised definitions applicable to aged care that are provided by the external benchmarking service to identify infections. The type of surveillance undertaken is appropriate to the aged care service with data collected on urinary infections, influenza, skin infections and respiratory tract infections. There is a monthly collection and collation of the types and numbers of infections for this rest home and hospital service. There have been no infection outbreaks since the previous audit. The data and reporting of the statistics and analysis is provided to the organisational wide governance/quality team. The outcomes are fed-back to the staff at the next staff meeting. Graphs are produced that identify any trends for the current year and comparisons against previous years, and this is reported to the nurse manager. Data is benchmarked externally within Metlifecare. Benchmarking has provided assurance that infection rates at this facility are below average for the sector.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the use of both restraints and enablers should they be required. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. The nurse manager demonstrated a sound understanding of the organisation's policies, procedures and practice as the restraint coordinator was not available during the audit. Policy states that enablers are the least restrictive option and used voluntarily at the resident requests.

		<p>The facility is restraint free at the time of audit and the last restraint identified in the restraint register is an enabler which was removed in October 2017.</p> <p>Restraint would only be used as a last resort when all alternatives have been explored. Staff interviewed confirmed their knowledge of restraint management. Education occurred in December 2017 and is a compulsory annual education for clinical staff.</p>
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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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	CI	<p>Metlifecare Powley can demonstrate that having fully attained this criterion, the service can in addition, clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those finding, and improvement to service provision related to resident safety or satisfaction as a result of the review process. Reporting of data by the nurse manager includes the use of a clinical dashboard which is completed monthly. This covers finances, occupancy, infection control, pressure injuries, falls, weight loss of residents and if a resident has lost 5% of their body weight in four weeks or 10% over a six-month period a full individual dietitian review is undertaken and corrective measures are implemented. Restraint use is reported and a restraint free environment has been achieved and maintained by Metlifecare Powley since October 2017. Two person lift information is reported to assist with staff rostering numbers and the use of antipsychotic and antidepressant medication is trended; if this is seen to increase senior management meet with the GP to discuss this.</p> <p>All incidents and accidents are entered into an electronic system and reviewed weekly by the nurse manager and the clinical quality and risk manager. An</p>	<p>Key components of service delivery are implemented, reviewed, audited and reported at all levels of the service through to board level. This ensures quality management systems are being monitored to include corrective action implementation and follow up outcomes as required.</p>

		<p>electronic risk management system is used to record all staff incidents and accidents. This information is taken to the clinical nurse team leaders meeting, which is chaired by the clinical nurse director of Metlifecare and then it is taken to the quarterly governance meetings with results of corrective action follow up described and reviewed. One example of an action undertaken at governance level to address an issue is the introduction of meal choices for every resident for each meal which has been implemented at all Metlifecare facilities. The results of this will be measured in the 2018 resident satisfaction survey.</p>	
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Quality improvement data are collected, analysed and evaluated. The results are communicated to service providers and residents where appropriate. Metlifecare Powley can demonstrate that having fully attained this criterion the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those finding, and improvement to service provision related to resident safety or satisfaction as a result of the review process. All quality information is shared with staff across the organisation from the time the analysis and evaluation has occurred. For example, if an internal audit identifies that the required standard has not been met then this is shared at the staff daily handover, documented in the communication book with the findings clearly shown and the actions required to be undertaken to make an improvement. Staff feedback is sought and all actions are evaluated and documented to show if they have improved service. Staff stated during interview that they work as a team and that they are kept fully informed about quality improvement data. Examples discussed related to emergency management processes, falls management and resident weight management. Quality improvements are shared at residents' meetings as appropriate.</p> <p>All data results are also taken to staff meetings and presented in a manner that staff understand. Meeting minutes and data results are displayed for all staff to see.</p>	<p>Staff are kept fully informed about quality improvement data including outcomes of corrective actions undertaken on a 'real time' basis. Staff input into quality improvements is acknowledged and documented in data sighted. Staff knowledge and understanding of improvements required via corrective actions or projects undertaken has created a culture of staff 'buy-in' of quality improvements put in place.</p>
<p>Criterion 1.4.7.1</p> <p>Service providers</p>	CI	<p>Staff receive appropriate information, training and have equipment to respond to emergency and security situations including fire. On the 10 April 2018 a power outage occurred caused by poor weather conditions in the Auckland region.</p> <p>Having fully attained the criterion the service can in addition clearly demonstrate</p>	<p>Staff and management displayed good knowledge and skills during the recent power outage, with little disruption to residents and services provided. All emergency equipment and supplies</p>

<p>receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>		<p>a review process including analysis and reporting of findings, evidence of action taken based on those finding, and improvement to service provision related to resident safety or satisfaction as a result of the review process. The power was off for four days and was reinstated on the night of the 14 April 2018. During this time services were maintained to a high standard as confirmed during staff, resident and family interviews. Documentation identifies actions taken and learnings gained by this event. When the power went out the generator supplied emergency lighting which included full corridor lighting which gave light into residents' rooms. Staff used civil defence equipment such as torches, head lamps and some disposable equipment to carry out day to day cares.</p> <p>Hot water was available from the kitchen area as this is run on gas and residents had hot water in a bowl to wash with.</p> <p>Initially medication management which is electronic was transferred to the offline medication administration system. The tablets and cellphones were initially charged via a laptop and power bank as a short term solution. A small generator was purchased soon after to do these tasks. The medication fridge was also run off this generator and the cold chain was maintained. More mobile phones were purchased for staff to use on duty.</p> <p>Landline phones could be used for outgoing calls to other landlines but not to cell phones. Staff were aware that the landline could be used to call emergency services if required.</p> <p>The kitchen was able to function as it had gas cooking and expert advice was sought from off-site food specialist companies. Chiller food was discarded after day two. Day to day food including milk was placed in a mobile chiller room which was hired. The hired food chiller room run off its own petrol generator. This was required to be topped up two hourly and the maintenance team undertook this task throughout the power outage. Food temperatures were maintained and recorded by kitchen staff. Two meals were brought in from a sister facility to relieve kitchen staff during the power outage.</p> <p>Laundry was taken to a sister facility by the Powley staff and then returned to the facility on the same day. No issues arose around laundry.</p> <p>As the call bells were not working, two additional staff where placed on all shifts so that residents could be closely monitored at all times. These extra staff remained on the roster for two additional days after the power was reinstated to allow Powley staff to catch up on incomplete tasks, such as cleaning, and to lighten the workload. It was recognised by Metlifecare that many of the staff also</p>	<p>were back in place two days post the power outage as observed during audit. Deficits identified by staff have been clearly documented and will be reviewed at governance level at the earliest timeframe available. 'Easy fix' deficits such as the purchase of more cell phones and an additional small generator to power the medication tablets and cell phones has been implemented and therefore improvements have been made to the service should another emergency occur.</p>
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		<p>went home to no power over this time.</p> <p>Every resident was issued with extra blankets as there was no heating. No complaints about being cold were received.</p> <p>Arrangements were made to swap oxygen concentrators with oxygen bottles.</p> <p>The DHB offered assistance regarding any clinical concerns or if any high needs residents' required temporary relocation.</p> <p>A section 31 report was made to the Ministry of Health.</p> <p>On the third day of the power outage a large industrial generator was hired so all services could be used.</p> <p>Staff have had input into a list of items they identified that could assist in the case of another emergency. The debrief is to occur on the Monday following this audit with members of Metlifecare senior management team.</p> <p>Learnings gained are:</p> <p>The need to investigate the updating of the call bell system so it can operate as part of the emergency backup system.</p> <p>The value of obtaining a battery-operated vacuum cleaner.</p> <p>Having nominated power points that operate when the emergency generator cuts in.</p> <p>The development of a step by step instruction chart for the manual use of the on-site generator should it not cut in automatically.</p> <p>Developing a family communication method such as an email merge so it is not so time consuming to notify all families of the occurrence.</p> <p>Installation of an outside plug that can be used for additional generators that may be used on site.</p> <p>More lighting needs to be installed around the nurses' station.</p>	
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End of the report.