

# Metlifecare Limited - Metlifecare The Avenues Ltd

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## 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:

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| <b>Legal entity:</b>  | Metlifecare Limited  |
| <b>Premises audited:</b>  | Metlifecare The Avenues Ltd  |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| <b>Dates of audit:</b>  | Start date: 28 June 2021    End date: 29 June 2021   |
| <b>Proposed changes to current services (if any):</b>   | None   |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 29   |

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Metlifecare Limited - Metlifecare The Avenues Ltd (The Avenues) opened in September 2019 and provides rest home and hospital level care for up to 30 residents. All beds are suitable for either rest home or hospital level care. The service is operated by a nurse manager and a senior registered nurse with oversight from the village manager and a regional clinical manager. There has been change in the ownership of Metlifecare. This has not impacted on service delivery.

Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, and a nurse practitioner. This is the first full certification audit against the Health and Disability Sector Standards as the initial scheduled audit was deferred due to the national Covid-19 pandemic.

This audit has resulted in three continuous improvements in relation to good practice / quality improvement processes, the admission processes, and restraint elimination. There are two areas identified as requiring improvement. These relate to food safety training and monitoring of resident's post falls.

## 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.

All standards applicable to this service fully attained with some standards exceeded.

Residents and their family/whānau 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. The services provided support personal privacy, independence, individuality, and dignity. Staff interact with residents in a respectful manner.

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

There is a Maori health plan to guide staff to ensure that residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect, or discrimination.

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

Information about how to make a complaint is readily available. Few complaints are received, and these have been investigated and responded to promptly.

## 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.

The business and quality plans included the scope, goals, and values of the organisation. There are appropriate processes in place to monitor and report on key aspects of service through to senior managers / executive team. An experienced and suitably qualified person manages the facility, and is supported by and senior registered nurse and an experienced regional clinical manager.

The quality and risk management system includes internal audits, satisfaction surveys, collection and analysis of quality improvement data including internal and external benchmarking, and quality improvement projects.

Adverse events are documented with corrective and quality improvement actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

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

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

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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The admission process is efficiently managed by suitable personnel, with relevant information provided to the potential resident/family. The registered nurses and general practitioner or nurse practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Routine care plan evaluations are completed in a timely manner. Residents are referred or transferred to other health services as required.

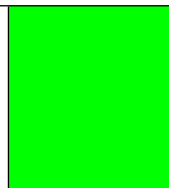
The planned activities programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

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

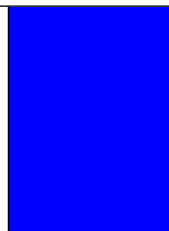
The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment has been tested as required. Clinical equipment has evidence of current performance monitoring / clinical calibration. Communal and individual spaces are appropriately ventilated and maintained at a comfortable temperature. External areas are accessible, safe and provide sufficient shade and seating.

Waste and chemicals / hazardous substances are stored securely. Staff use protective equipment appropriately. Laundry is undertaken offsite. Cleaning is undertaken by employed staff daily.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. The fire evacuation plan has been approved by the New Zealand Fire Service. Fire drills are conducted at least six monthly. Call bells are appropriately located. Security cameras are in use and security systems are appropriate for the services provided.

## 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.

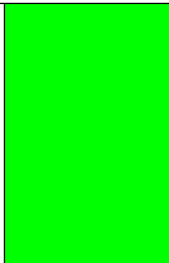


All standards applicable to this service fully attained with some standards exceeded.

Policies and procedures that support the elimination of any form of restraint are in place. There are no restraints in use, and restraints have never been used on site. One resident is using an enabler.

Staff described a sound knowledge and understanding about restraints and enablers and were aware of any use of an enabler is to be voluntary and according to the person's request.

## Infection prevention and control

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

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. There have been no infection outbreaks since the last audit.



## 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 3                           | 40                  | 0  | 1                                    | 1  | 0                                      | 0  |
| <b>Criteria</b>   | 3                           | 88                  | 0  | 1                                    | 1  | 0                                      | 0  |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 0  | 0                            | 0                                      | 0                              | 0                                      |

# Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome  | Attainment Rating | Audit Evidence   |
|--|-------------------|--|
| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>   | FA                | <p>The Avenues has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). The interviewed staff understood the requirements of the Code and were observed communicating with residents in a respectful manner. The residents confirmed that options are provided, dignity and privacy is maintained during care provision, and they are encouraged to maintain their independence. Training on the Code is included as part of the orientation process for all staff employed and in ongoing mandatory training, as was verified in training records.</p>  |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p> | FA                | <p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately as part of the organisation's admission agreement. Advance care planning is encouraged, and these were sighted in residents' files where applicable. "Shared goals of care" were documented, and resuscitation treatment plans completed in the residents' files reviewed. Influenza and Covid-19 vaccination consents were obtained for residents who received the vaccinations. Documentation in relation to enduring power of attorney (EPOA) and processes for residents unable to consent is defined and documented, as relevant. EPOA documentation was sighted in residents' files reviewed and where appropriate, these were activated. Staff were observed to gain consent for daily care. The interviewed</p> |

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| consent.  |    | residents and family/ whānau confirmed being consulted and provided with information in relation to treatment plans.  |
| Standard 1.1.11: Advocacy And Support<br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.       | FA | Residents are given a copy of the Code, which also includes information on the Advocacy Service during the admission process. Information on Advocacy services is included in the admission agreement. Posters and brochures related to the Advocacy Service were also displayed at the reception area. Family/whānau and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The SRN provided examples of the involvement of support people in relation to provision of care and care planning. Staff have received training on Advocacy Services.   |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br>Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. This was confirmed by the interviewed residents. A variety of visitors were observed visiting residents during the days of the audit.<br><br>The facility has unrestricted visiting hours and encourages visits from residents' family/whānau and friends. Family/whānau interviewed stated they felt welcome when they visited and comfortable with staff attitudes and communication with them.  |
| Standard 1.1.13: Complaints Management<br>The right of the consumer to make a complaint is understood, respected, and upheld.                                 | FA | 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. Feedback forms are also available with a 'drop box' at the main entrance.<br><br>The complaints register is maintained detailing all complaints received. The nurse manager is responsible for complaints management, with the support of the regional clinical manager. The regional clinical manager stated the process that would be undertaken should any oral or written complaints be received.<br><br>A review of six complaints demonstrated that these have been investigated and followed up in a timely manner. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from the District Health Board, Ministry of Health or Health and Disability Commissioner since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service  | FA | The interviewed residents reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided. Advocacy service  |

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| <p>Delivery</p> <p>Consumers are informed of their rights.</p>   |    | <p>information is included in the admission agreement and is discussed with the residents and family/whānau on admission. Family/ whānau of choice where appropriate or residents' legal representatives are involved during the admission process and explanation on the Code is provided to them when required. This was confirmed in family/whānau interviews conducted. The Code posters, written in English and Maori were displayed at the reception area together with information on advocacy services, how to make a complaint and feedback forms.</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>Residents and family/whānau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices. Staff were observed to maintain privacy throughout the audit. Residents confirmed that their personal belongings are safe, and they receive their laundry back after laundering.</p> <p>Residents are encouraged and supported to attend to community activities and to participate in activities of own choice. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Interviewed staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | FA | <p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. Residents' cultural values and beliefs are assessed on admission as part of the admission process. A Maori health care plan was sighted in the resident's file reviewed. The principles of the Treaty of Waitangi are incorporated into daily practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. There is a nominated cultural advisor for the service. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Tikanga flipcharts were posted around the facility. Residents who identify as Māori reported that staff acknowledge and respect their individual cultural needs.</p>  |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally</p>  | FA | <p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed. For example, residents who wish to go to church services outside the facility were supported by family/ whānau and this was documented in the care plans reviewed. Room blessing is conducted for all rooms post resident's death. The resident satisfaction survey confirmed that individual</p>  |

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| safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.   |    | needs are being met.  |
| Standard 1.1.7: Discrimination<br>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.              | FA | Residents and family/whānau interviewed stated that residents were treated fairly with no discrimination, harassment or exploitation and they felt safe. The orientation process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. There are policies and procedures to guide on processes to follow should they suspect any form of exploitation. The staff demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.   |
| Standard 1.1.8: Good Practice<br>Consumers receive services of an appropriate standard.  | CI | <p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, palliative care team, wound care specialist, geriatrician and mental health services for older persons, and education of staff. The nurse practitioner (NP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Online education is provided, and toolbox talks at handover times.</p> <p>There is a guest room that residents' family/whānau can utilise when they need to stay over to be close to the family especially in end-of-life care.</p> <p>Other examples of good practice observed during the audit included several quality improvement projects implemented to improve residents' care. These include assessment and management of acute confusion, promoting increase in vitamin D uptake for residents, early end of life care discussions and documentation and upgrading of the admission agreement to reflect the nurse practitioner's involvement in residents' care.</p> |
| Standard 1.1.9: Communication<br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident 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. Staff receive training on communication and documentation with the last one completed on 31/05/21.</p> <p>The senior registered nurse (SRN) and registered nurses (RN) knew how to access interpreter services</p>  |

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|   |           | <p>through the local DHB and use of family/whānau. Staff reported this was rarely required due to all residents able to speak English, family/whānau and staff able to provide interpretation as and when needed. Card prompts with pictures are also used for residents with communication difficulties.</p>   |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>Metlifecare was brought out by the EQT Asia Pacific Care Group in November 2020. The Metlifecare name has been retained, with changes to the board of directors and a new Chief Executive Officer has been appointed (June 2021). A three to five year, 'Full Potential Plan' is being rolled out. There are 11 care homes in the Metlifecare group.</p> <p>The Avenues has a 2021/2022 business plan. This includes evidence of a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis, goals, actions and measures, budget planning and goals relating to risk identification and management, quality improvement and resident focused services. Core values of passion, respect, integrity and teamwork remain. The changes in ownership are not expected to have any impact on current residents or services.</p> <p>Each month the nurse manager provides a monitoring report to The Avenues village manager and the regional operations manager, the general manager of operations and finally the chief executive officer. The senior registered nurse and the nurse manager work alongside the experienced regional clinical manager. The regional clinical manager reports to the clinical director who has been a member of the Metlifecare executive team since 2016, and worked at Metlifecare for six years. The executive team meet weekly and the meeting agenda includes relevant components to monitor the organisations performance. The clinical director meets individually with other members of the executive team as required.</p> <p>This service is managed by the nurse manager who was appointed approximately three months prior to The Avenues opening. The nurse manager (NM) started working in other Metlifecare care homes to become familiar with Metlifecare systems and processes. The nurse manager was on leave during this audit. The regional clinical manager (RCM) has been on site during the NM leave period supporting the experienced senior nurse (who is new at Metlifecare; commencing in May 2021). The NM and senior registered nurse (RN) responsibilities and accountabilities are defined in their job description and individual employment agreement. The regional clinical manager confirmed knowledge of the sector, regulatory and reporting requirements. The nurse manager has exceeded eight hours of education related to managing an aged residential care service in the last 12 months.</p> <p>The RCM has access to the resident electronic care record and notes reviewing resident records most days, and is aware of the resident's care needs and any significant changes.</p> <p>The service holds contracts with the Bay of Plenty District Health Board to provide rest home and hospital level aged care services under the Age-Related Residential Care (ARRC) Agreement. All beds are dual purpose beds for rest home or hospital level care. At the time of audit 21 residents were receiving hospital</p> |

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|  |    | level care and seven at rest home care under this agreement. There is one other resident receiving hospital level care under contract with Accident Compensation Corporation (ACC).  |
| <p><b>Standard 1.2.2: Service Management</b></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>In the absence of the nurse manager, the senior registered nurse would normally be responsible for services delivered under delegated authorities with the support of the village manager and regional nurse manager. As the senior nurse is new (employed in May 2021), the regional clinical manager is currently responsible for the services provided, and is undertaking this along with the regional clinical manager responsibilities.</p> <p>There are other senior registered nurses, and nurse managers within the cluster of Metlifecare facilities in the Bay of Plenty to provide additional support if required. Staff reported the current management arrangements and availability of registered nurse advice work well.</p>  |
| <p><b>Standard 1.2.3: Quality And Risk Management Systems</b></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 documented continuous quality improvement (CQI) programme (July 2020 to June 2022). The planned quality and risk system reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, resident and family satisfaction surveys, monitoring of outcomes, health and safety reporting, hazard management, clinical incidents including infections, falls and skin injuries.</p> <p>There is a national 'heart of gold' staff awards programme where staff can nominate colleagues for national recognition. This has recommenced in 2021 after a year recess due to Covid-19 pandemic.</p> <p>The Metlifecare national clinical governance committee meets two monthly. This meeting is attended by the clinical director, the regional clinical managers, a nurse manager representative, a village manager representative and the organisations nurse educator. A resident living in one of the retirement villages is also a member of committee. Minutes of three meetings demonstrate a coordinated approach to assessing and monitoring key components of service delivery, quality and risk. There are bi-monthly national clinical manager team meetings. These are held alternate months to the clinical governance meeting ensuring regular review of quality and risk issues.</p> <p>Resident and family satisfaction surveys are completed annually; however, these were not distributed in 2020 due to COVID-19. The 2021 survey is being overseen by an independent company that has recently distributed the questions. The results are due mid-July, therefore not available at the time of audit.</p> <p>There is a national internal audit calendar and templates audit templates are in use. The results show there is a predominantly compliance with organisations policies. However, where the audit result was under the required target rate, corrective actions were implemented and a re-audit completed. The results of at least</p> |

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|  |  | <p>nine audits were sighted during audit.</p> <p>The Avenues staff meeting minutes reviewed confirmed regular review and analysis of incidents, audit results, complaints/concerns, restraint free status, and infections. Related information is reported and discussed at the regular registered nurse meetings and care staff meetings. There are also regular resident meetings occurring and topics include food, activities, laundry, call bells, staffing and aspects of the environment.</p> <p>Relevant corrective actions by way of quality improvement plans, are developed and implemented to address any shortfalls with a focus on system and process improvements. These are regional wide quality improvement initiatives undertaken. A continuous improvement rating has been noted in 1.1.8.1 (good practice), 1.3.1.4 (admission processes), and for 2.1.1.4 (restraint minimisation). A register is maintained of local quality improvement activities/programmes.</p> <p>Benchmarking is undertaken internally and externally of a range of clinical events. The results are reported and discussed at the clinical managers meeting, the clinical governance meeting and with applicable staff on site. The CRM advised the internal benchmarking programme has been expanded in June 2021 to include the number of residents and staff that have completed both Covid-19 vaccinations. The clinical director provides a summary report of the clinical indicator data with a narrative per care home and overall Metlifecare rates, with monthly and rolling average rates per 1000 occupied bed days to the executive. In addition comparison graphs with other external providers for specific clinical indicators. Metlifecare has no restraints in use in any of the care homes in variance to other benchmarked facilities. Overall Metlifecare is also below the medium for polypharmacy and medication errors.</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 current and readily available to staff on the intranet (MetNET). The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The regional clinical manager and the clinical director (by telephone interview) described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk register is an electronic document and is regularly reviewed by executive team and the board of directors, and the clinical risk component was sighted during audit. The clinical director reported being very satisfied that new and changing risks are communicated in a timely manner, and mitigation strategies implemented and monitored for effectiveness.</p> <p>The management team is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The hazard register and staff incident data is reviewed at the health and safety meetings.</p> |
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| <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 in the electronic client management record (ECMR). 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. Open disclosure has occurred in a timely manner and communications with family members were comprehensive and clearly documented for sampled events.</p> <p>Adverse event data is collated, analysed and reported to relevant staff and managers.</p> <p>The RCM described essential notification reporting requirements, including (but not limited to) pressure injuries, significant health and safety events, loss of utilities, changes in managers, and registered health professional competency concerns. The RCM advised there have been notifications of significant events made to the Ministry of Health or the DHB since the previous audit and documentation was sighted. This includes the appointment of the nurse manager (September 2019), injuries to a resident that occurred while the resident was offsite (July 2020), and residents with a pressure injury stage three or above. Another section 31 notification was made by another regional manager in relation to the change in ownership of Metlifecare.</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 completing an application, interview, 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 implemented and records maintained. All employed and contracted registered health professionals have a current annual practising certificate with records sighted.</p> <p>Staff orientation includes all necessary components relevant to the role, including a buddy system. There are a number of self-learning programmes that are required to be completed along with a role specific checklist and competencies. Staff reported that the orientation process prepared them well for their role, and additional time can be allocated where required. Staff records reviewed included documentation of completed orientation and competency / training requirements. There is a documented orientation programme for agency staff and records of completion maintained the first occasion the agency staff member attends for a shift.</p> <p>Continuing education is planned over a two-year period (2021-2023), and includes mandatory training requirements. There are mandatory training days, that are repeated during the year and staff must attend one of these dates per year. New staff are rostered onto the next mandatory training day available after they commence. Topics cover those as required by the DHB contract, to meet these standards, and topic issues including COVID-19. Staff are provided with hand hygiene, and donning and doffing training / competency. There is a national nurse educator that is reported to oversee the education programme. The</p> |

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|   |           | <p>RN's advise the education is comprehensive and detailed where required. The RCM assists with education as appropriate, including related to the new quality initiatives.</p> <p>Care staff are supported to obtain an industry approved qualification if they do not have one on employment. Staff advise they enjoy the education opportunities provided and annual study day is complimented by a range of in-services, or other education opportunities including with the physiotherapist, product specialists, nursing team / manager or in response to current resident care needs.</p> <p>There are two trained and competent registered nurses who maintain annual competency requirements to undertake interRAI assessments, with another RN needing to transfer InterRAI access to The Avenues and complete the annual competency reassessment process.</p> <p>Records reviewed demonstrated completion of the required training with the exception of food safety training (refer to 1.3.13.1) and annual Connect2 reviews (performance appraisals) have been undertaken.</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>A staffing rationale and rostering policy and procedure states the care home will be staffed in line with recognised, relevant guidelines and evidence-based literature and that staffing will also enable cost effective and efficient quality care. Rostered hours are guided by the recommendations in the NZ Handbook: Indicators for Safe Aged-care and Dementia-care for Consumers SNZ HB 8163:2005, from which an Expert Advisory Panel (EAP) have devised a staffing tool. The regional clinical manager informed that a separate high dependency tool is being trialled and results are being compared with the existing acuity/staffing tool. The regional clinical manager confirmed the residents' needs are considered when finalising working rosters. The CRM regularly uses the acuity tool to review the number of residents for each assessed level of care and staffing needs and examples of these completed tools, and staffing calculations were sighted.</p> <p>A roster framework determines the staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). There is a set roster in place for RN's and caregivers covering a two-week period. The rosters are issued by the nurse manager, a month in advance. There are sufficient allocated hours for domestic aids, activities, catering staff and the receptionist, verified by staff interviewed and review of the roster. The maintenance person provides services for the village and care home. Laundry services are undertaken of site with the exception of cleaning and kitchen related laundry.</p> <p>The nurse manager is also a registered nurse, and is scheduled to be on call when not on site. In the NM absence, the senior nurse and/or the regional clinical manager takes on this role. There is also access to GP or NP on call and to registered nurses in three other facilities in a local Metlifecare cluster.</p> <p>Care staff reported there are sufficient staff rostered on each shift. There were no concerns raised by residents and family interviewed about staffing levels. Observations and review of four random weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence, or</p> |

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|   |    | <p>shifts extended. A casual pool shared with three other facilities is available. External agency staff (caregivers and registered nurses) are also sourced if required. Where possible the same person is booked as they are familiar with the residents, facility and routine. The regional clinical manager advised there are no staff vacancies, however staffing has been impacted by immigration / visa issues including restrictions (re) entering the country for non-New Zealand residents/citizens.</p> <p>There is 24 hour/seven days a week (24//7) registered nurse coverage for the hospital and as all registered nurses and activities staff are required to have a current first aid certificate, there is always at least one person on duty with a current first aid certificate. The minimum number of caregivers on duty was increased to two on 10 May 2021 equating to at least three staff being present at all times. Staff are not required to attend call outs to residents living in the village as verified by interviewed with care staff and the RCM.</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>            | FA | <p>There is an electronic information management system in use and paper-based files for admission information including financial documents and admission agreements. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP or NP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. Staff have individual passwords to access the resident's electronic records. Residents' records in paper files were stored in locked stationery cabinets in the nurses, station. No personal or private resident information was on public display during the audit.</p>                                   |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | CI | <p>The residents' clinical records sighted demonstrated that residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their family/whānau are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process in the information booklet. Updated information from NASC and GP is sought for residents accessing respite care. There were no residents receiving respite care on the days of the audit. The Avenues care home information booklet is provided to all new residents, and it contains information on the services provided and house rules.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Additional</p> |

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|  |    | costs were documented in the admission agreement and service charges comply with contractual requirements. Improvements to admission agreement and associated documents and communication processes are an area of continuous improvement.   |
| <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>There is a discharge, exit, transition, or transfer process in place that is managed in a planned and coordinated manner, with an escort provided as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed that appropriate information was provided to enable continuity of care for the resident. Family of the resident reported being kept well informed during the transfer of their relative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. The nursing team, the receptionist and the accounts team are all involved in the discharge process. This was verified in the discharged resident's 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 Avenues' medication management policy was current and identified all aspects of medicine management in line with the current legislative requirements. An electronic medicine management system in use and was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines had current medication management competencies.</p> <p>Medicine is stored in a lockable medication room and in locked medication trolley. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription and the checks are recorded on the electronic medication management system. All medications in use and in stock sighted were within current use by dates. Clinical pharmacist input is provided on request. The residents' electronic prescription charts had current residents' photos.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. Monthly medication management audits were implemented following an identified gap in the medication management system. Comprehensive analysis of medication errors and implementation of corrective actions was completed. Medicine fridge and medication room temperatures were monitored, and records maintained. The reviewed records were within the recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and</p> |

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|   |        | <p>discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly medication reviews were consistently completed by the GP or NP and recorded on the electronic medicine chart.</p> <p>There were three residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner</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> | PA Low | <p>The food service is provided on site and is in line with recognised nutritional guidelines for older people. The menu follows the seasonal patterns and has been reviewed by a qualified dietitian on 16 June 2021. Recommendations made at that time have been implemented. A diet requirements form is completed on admission for all residents and a copy is provided to the kitchen team. Copies of these were sighted in the kitchen folder. Residents' personal food preferences, allergies, special diet and modified texture requirements are made known to the kitchen staff and are accommodated in daily meal plan.</p> <p>The daily menu is written on the white board in the two dining rooms in use. There are two menu options for each meal and the kitchen staff goes around to residents each day to ask them to choose the option they prefer for the following day. The main meal is serviced at lunchtime. Hot boxes are used to transport food from the main kitchen to the dining rooms.</p> <p>The service operates with an approved food safety plan and registration issued by the local City Council. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The kitchen and pantry were clean, and no food items were on the floor. There was no expired food in stock. All the decanted food in the fridge was covered and labelled. Special equipment, to meet resident's nutritional needs, is available. There was no evidence of food handling training for kitchen staff with the exception of one staff in the staff records reviewed.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion 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 service is declined, the immediate risk to the consumer and/or their family/whānau is managed by</p>     | FA     | <p>The SRN reported that if a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. They can also be put on the waiting list and will be contacted when a vacancy becomes available. There is a clause in the admission agreement related to when a resident's placement can be terminated.</p>   |

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| the organisation, where appropriate.  |                |  |
| Standard 1.3.4: Assessment<br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.                               | PA<br>Moderate | Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity and interRAI momentum tool, as a means to identify any deficits and to inform care planning. An additional formal tool for assessing acute confusion in residents was implemented (Refer 1.1.8). The sample of care plans reviewed had an integrated range of resident-related information. All residents had current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and family/whānau confirmed their involvement in the assessment process. The post fall neurological monitoring was not consistently completed as per organisation's policy.   |
| Standard 1.3.5: Planning<br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.                       | FA             | The care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. The care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. The SRN reported that any change in care required is documented and verbally passed on to relevant staff. This was verified by interviewed staff and observed in the handover witnessed. Residents and family/ whānau reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions<br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA             | The reviewed documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident in all areas of service provision. The interviewed NP confirmed that medical input was sought in a timely manner and that medical orders are followed, and care is implemented promptly. 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.  |
| Standard 1.3.7: Planned Activities<br>Where specified as part of the service delivery plan for a consumer, activity   | FA             | The activities programme is provided by the activities coordinator Mondays to Friday and every second Sunday. The activities programme is completed by the activities coordinator with the support of the nurse manager. The activities coordinator has been in this position since November 2020. Activities are combined for rest home level and hospital level residents. The activities programme is regularly reviewed in three monthly residents' meetings to help formulate an activities programme that is meaningful to the residents.  |

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| <p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>  |           | <p>This was verified in the residents' meeting minutes sighted.</p> <p>A social assessment and history assessment is completed on admission via the assessment form provided to residents or family/whānau to ascertain residents' needs, interests, abilities, and social requirements. The activities coordinator completes the organisation's activities assessment and plan form using the information from the resident and family/whānau and their own observation. A copy of the monthly activities plan is given to each resident and posted on the notice boards around the facility. The residents' activity needs are evaluated six-monthly as part of the formal six-monthly care plan review.</p> <p>The activities on the calendar reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. The activities on the programme included weekly van outings, church services, special occasion celebrations, quiz, coffee club and exercises.</p> <p>Daily activities attendance records were maintained, and residents were observed participating in various activities on the days of the audit. The interviewed residents confirmed they find the programme satisfactory.</p> |
| <p>Standard 1.3.8: Evaluation<br/>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | <p>FA</p> | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Routine care plan evaluations occur every six months following the six-monthly interRAI reassessment, or as residents' needs change. Goals of care were reviewed and updated in response to evaluation of progress. The reviewed resident's records demonstrated that where the desired goal was not met, the service responded by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for urinary tract infections and wounds. Unresolved problems were added to long term care plans. Staff are informed of any changes to plan of care at verbal handovers. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>   |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br/>Consumer support for access or referral to other health and/or disability service providers is appropriately</p> | <p>FA</p> | <p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP/NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to orthopaedic department and eye specialists. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews with residents and family/whānau. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. Examples of this was sighted for a resident who had sustained injury following a fall and was transferred to the local DHB via ambulance.</p>  |

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| facilitated, or provided to meet consumer choice/needs.  |    |  |
| <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. Waste and recycling is appropriately segregated and collected by contractors. Appropriate signage is displayed where necessary.</p> <p>An external company is contracted to supply all cleaning products, and these are stored appropriately. Staff verify they are provided with relevant training. Material safety data sheets, and emergency instructions were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. A spill kit is located on site and was sighted.</p> <p>There is provision and availability of appropriate personal protective equipment (PPE) and staff were observed using this appropriately.</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 18 August 2021) was publicly displayed. Ongoing checks to maintain the building warrant of fitness are occurring.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Some rooms have an adjoining door that can be opened and used for the care of a couple in co-located rooms. The doors are secured when not in use. Sensor beams can be set in resident rooms each night alerting staff of mobile residents. The testing and tagging of electrical equipment and calibration of bio medical equipment was current (completed November 2020) as confirmed in documentation reviewed, interviews with the maintenance manager and observation of the environment. Four rooms have ceiling mounted hoists in situ. These have been most recently tested by the installing company in October 2020. Water temperature testing was reviewed and this is completed monthly with appropriate temperatures being maintained. The environment was hazard free and resident safety was promoted.</p> <p>The facility has a transit van vehicle which has a current registration, warrant of fitness, first aid kit. Staff noted the vehicle can transport up to 11 residents, a staff member, and the driver.</p> <p>External areas are easily accessed, safely maintained and were appropriate to the resident group and setting. This includes an internal courtyard, and small external courtyard/area off the bedrooms.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that any requests are actioned in a timely manner. This was verified by reviewing maintenance requests records. There is a monthly inspection checklist that is completed during each month and these have been completed. All residents and family members were very satisfied with the environment.</p> |



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| <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>Each resident's room has an ensuite that includes a toilet, wet area shower and a hand basin. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories according to individual requirements, are available to promote resident independence. There is a staff toilet and shower and a visitor toilet.</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. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There are areas for the storage of other equipment including mobility aids, wheelchairs and clinical consumables. Staff and residents reported the rooms are sufficiently spacious, with sufficient space to use hoists and other mobility equipment.</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>The Avenues comprises two 'homesteads' containing 15 bedrooms. Each 'homestead has its own lounge, dining and kitchen area that can be used by residents and family members including for birthday celebrations. There is a small quiet space at the end of each corridor. All meals are prepared in the main kitchen. There is a corridor that goes to the collocated retirement village.</p> <p>All dining and lounge areas are spacious and enable easy access for residents and staff. Furniture is appropriate to the setting and residents' needs. Communal areas are also used for the activities programme and for residents' individual activities. Residents and family members interviewed confirmed the facility is well maintained and 'homely'.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p>  | FA | <p>Laundry is undertaken off site for reprocessing. Some laundry, including resident's personal laundry, is picked up daily and returned the next day, after laundering at another facility in the Metlifecare group. Sheets, pillowcases and towels are laundered by another contracted laundry service, collected daily</p>  |

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| <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>weekdays and on Sundays over a long weekend.</p> <p>Care givers were aware of the segregation and handling of soiled linen processes and need to ensure the laundry is ready for the morning pick up. Residents interviewed reported their laundry is managed well and their clothes are returned in a timely manner with rare exception.</p> <p>There are two staff in the domestic aid team, with one working daily. The domestic aids have received appropriate training including chemical safety provided by the chemical supplier. Chemicals were stored securely and were in appropriately labelled containers. A chemical auto-dispenser is utilised. A cleaning schedule details the tasks to be completed, frequency and product to be used. Cleaning and laundry processes are monitored through, the internal audit programme, resident meetings, and the 2021 resident satisfaction survey process with results pending.</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. A 'flip chart' is present as a quick reference.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on 12 August 2019 (EVAC-2019-415273-01). A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 15 March 2021. The new staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food for up to three days, water in roof tanks (three 600 litre tanks), with the content is kept fresh, blankets, batteries and gas BBQ's (with two spare gas bottles) were sighted to meet the requirements for the 30 residents. The gas bottles are checked annually. There is a connection to the building to enable a generator to be connected in the event of loss of power. There is an uninterrupted battery supply (UPS). The maintenance manager advised that this can be connected to any room to enable key equipment to function for up to four hours. Emergency lighting is regularly tested. The civil defence supplies are stored appropriately and checked six monthly. There are additional PPE supplies for use in an outbreak stored off site.</p> <p>Call bells alert staff to residents requiring assistance. These alert to staff pagers and to ceiling mounted panels. Call bells are present at the beds pace and in the bathrooms. Call system audits are completed on a regular basis and residents and family confirm their call bells are answered in a timely manner with rare exception.</p> <p>Appropriate security arrangements are in place. Surveillance cameras with appropriate signage are installed monitoring internal communal areas, the entrance and some external areas. Images can be displayed on the nurse manages computer, and are stored files are accessible by other authorised personal</p> |

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|   |    | only. Doors and windows are locked at a predetermined time and care staff note the check the security of all doors and windows when they close the window covering is each resident room at night. The RN is reported to double check later in the shift.   |
| <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>The Avenues uses heat pumps for warmth and cooling, with each resident's room having its own. These can be individually adjusted or 'locked' by the building and maintenance system. There is ducted heating in corridor and communal areas. The maintenance manager advises monitoring the ambient temperature to ensure it is appropriate for the season.</p> <p>Windows throughout the facility provide natural light and are openable with security latches in situ. All bedrooms have an external door onto a small deck courtyard area.</p> <p>All indoor areas were warm and well ventilated throughout the audit and residents and family members interviewed confirmed the facilities are maintained at a comfortable temperature.</p> <p>There is no smoking or vaping on site.</p>  |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The service has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual, with input from specialist services. The infection control programme is reviewed annually, it was last reviewed in January 2021.</p> <p>There is a designated IPC resource nurse from another facility in the same cluster. The IPC resource nurse has the support of the SRN and regional clinical manager. The IPC resource nurse's role and responsibilities are defined in a job description. A signed job description was sighted. Infection control matters, including surveillance results, are reported monthly to the regional clinical manager, and tabled at the staff meetings.</p> <p>There was signage at the main entrance to the facility requesting anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Hand sanitiser and COVID-19 tracer for contact tracing was accessible at the main entrance. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The interviewed staff understood these responsibilities.</p> |
| <p>Standard 3.2: Implementing the infection control</p>   | FA | <p>The IPC resource nurse has appropriate skills, knowledge and qualifications for the role, and has been in this role for two years. The IPC resource nurse is in the progress of completing a graduate certificate in</p>   |

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| <p>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>   |    | <p>infection risk management, as verified in training records sighted. Other relevant infection prevention and control education was completed by the IPC resource nurse and the SRN through webinars. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The IPC resource nurse and SRN have access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>There are processes in place for COVID-19 pandemic preparedness. Adequate resources to support the programme and any outbreak of an infection was available on site, and the regional clinical manager also stated that there is regional stock available if required. An immunisation plan for 2020-2022 was sighted. Residents and staff have received COVID-19 and influenza vaccine with the exception of those who did not want to receive these vaccinations. The service is aiming for above 80% of staff influenza vaccination uptake this year.</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 prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in April 2020 and included appropriate referencing. Site specific pandemic plan with current reviews and updates was sighted.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>  |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>  | FA | <p>Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation, through regular toolbox talks and in mandatory ongoing education sessions. Education is provided by suitably qualified SRN and the IPC resource nurse. Staff training records were sighted in the staff records sighted. Content of the training was documented and evaluated to ensure it is relevant, current, and understood. Additional infection prevention and control training was completed from March 2020 onwards for COVID-19 pandemic.</p> <p>One on one and group education were provided to residents and has included reminders about</p>   |

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|   |    | handwashing, advice about remaining in their room if they are unwell and increasing fluid intake when there is suspected or confirmed urinary tract infection. Examples of this was sighted in the short-term care plans and residents' meeting minutes reviewed. Other method of communication with residents and family/whanau for infection prevention and control issues was through emails.  |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, gastro-intestinal and the upper and lower respiratory tract. All infections are recorded into the electronic information management system and in the infection register. The IPC resource nurse and SRN reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and this is reported to the regional clinical manager and the clinical governance team at the national support office. Benchmarking with external specialist services is conducted quarterly and internally with other services under the same organisation. The results provided assurance that infection rates in the facility are below average for the sector, with no infections recorded for the rest home level residents from January 2021 up to date. There has not been an infection outbreak since the last audit.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>  | CI | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers, should any of these be required. The regional clinical manager informed that it is the nurse manager and senior nurse responsibility to ensure the facility meets the requirements of the restraint minimisation and safe practice standard. Staff undertake training about restraint and enabler use and in the management of behaviours that challenge.</p> <p>A continuous improvement attainment rating has been allocated for this standard as the organisation has not only minimised restraint use but has a strong philosophy in relation to the elimination of restraint use. This facility is demonstrating effectiveness with the philosophy as the managers reported that restraints have not been used since the facility opened on 19th September 2019. Documents sighted confirmed these reports. One resident is using an enabler.</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 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p> | PA Low            | <p>Food safety and handling training for kitchen staff is included in the orientation programme for kitchen staff. There are three chefs who are responsible for preparing meals and three kitchen hands who assist with serving meals and other kitchen duties. The reviewed kitchen staff training records evidenced one kitchen staff had received food safety and handling training.</p> | <p>Five out of the six kitchen staff training records sighted did not have evidence of food safety and handling training.</p> | <p>Ensure that all staff who work in the kitchen receive training in food safety and handling and provide evidence of the training.</p> |

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|  |                        |   |   | 180 days   |
| <p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p> | <p>PA<br/>Moderate</p> | <p>The organisation's post fall policy and procedure that guide staff states that monitoring of residents' level of consciousness for residents with suspected head injury is to be completed every two to four hours. Examples of incident records for residents who had a fall and were able to inform staff that they did not hit their head at the time of the fall and one set of neurological monitoring was completed. However, other incident records were sighted for residents who had cognitive impairment or had hit their head during the fall and the organisation's policy was not adhered to.</p> | <p>Four out four incident reports related to falls did not have neurological monitoring completed at the frequency required by the organisation's policy. Two falls were unwitnessed for a resident who had cognitive impairment and only one set of neurological monitoring was completed. An example was also sighted for a resident who had an unwitnessed fall at 07:50am and a set of neurological monitoring was completed at 11:07am and at 22:00pm. Another resident had a fall at 06:55am and sustained a head injury, the recorded neurological monitoring was at 13:47pm on the same day and the following day at 08:34am.</p> | <p>Ensure neurological monitoring is completed at the frequency required to ensure safety of residents.</p> <p>90 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 has implemented a number of quality improvement projects across three Metlifecare aged related residential care facilities in the region / cluster, sharing learnings from incidents, complaints or good practice initiatives including:</p> <p>I) Assessment and management of acute confusion for residents presenting with acute confusion was implemented to improve the assessment and management of residents presenting with acute confusion in response to a complaint received at another facility in this 'cluster' in relation to this. The process aims to ensure that the management of acute confusion considers the health and safety of the resident, as well as other residents and staff. Staff have received training in relation to the quality improvement initiative and records of the training was sighted. The use of the acute confusion assessment tool has been recently implemented at The Avenues Care Home and has enabled comprehensive assessment for resident who present with acute confusion.</p> <p>II) A quality improvement project to promote and increase the uptake of Vitamin D for residents was implemented following an organisation's benchmarking results of vitamin D uptake for residents within the organisation showed that The Avenues had the least number of residents on vitamin D. The strategies to addressing the needs involved registered nurses prompting the</p> | <p>The service is continually finding ways to improve the care of the residents as verified by the four quality improvement projects highlighted above namely use of acute confusion assessment form, encouraging vitamin D uptake for residents, end-of-life care assessment and involvement of family with timely conversations and review of the admission</p> |



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|   |           | <p>general practitioner (GP) and nurse practitioner (NP) to prescribe the vitamin D for new admissions and at three-monthly reviews. Where residents do not have the vitamin D prescribed, reasons for that are to be documented in the medical notes. The audit completed in May 2021 evidenced an increase in vitamin D uptake from 66% in February 2021 to over 90% in May 2021.</p> <p>III) A quality improvement in end-of-life care documentation was implemented following some feedback from family where it was identified end of life care discussions with family and documentation needed improvement. The project involved reviewing of end-of-life care assessment and management guidelines for the organisation as a whole. The objective was for care home residents who have been identified as having palliative care needs to have continual assessment for deterioration and early/timely conversations about end-of-life care with the residents and relevant family/whānau or significant others where appropriate. The end-of-life care plan was already part of the care planning requirements for all residents, and the improvement is around ensuring that family are involved and timely conversations to occur as per Te ARA Whakapiri guidelines. These residents are to have an end-of-life care plan created prior to any deterioration. The procedure implemented is for all admissions into the care home to have a documented “Goals of care” that identifies the level of care the resident wishes to have at end-of-life and prepares the family. This document was evidenced in all the resident’s files reviewed. The “Goals of care” form replaced the ceiling of intervention form that was in use before. An audit of the end-of-life care planning was conducted for the months of February to May 2021. The results verified that end of life planning included family and timely conversations were completed for all except the first applicable resident who required end-of- life care.</p> <p>IV) updating admission documents and processes (refer to 1.3.1.4).</p> | <p>agreement to include the medical services provided.</p>  |
| <p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their</p> | <p>CI</p> | <p>The admission agreement was reviewed and upgraded for the midlands cluster group of homes that include The Avenues. In particular, for The Avenues, it was in response to a complaint raised in relation to a resident not being seen by a GP, but rather a NP. There was lack of clarity and confusion around the care home’s GP/NP visits and the contracted medical service provider/cover. The previous admission agreement stated that GP services will be provided and did not include that the NP will also be used. The admission agreement was sent for legal review and was subsequently updated. To address the deficit in communication with residents and family/whanau around the medical services provided, the midlands group of care homes have put systems and processes in place to promote the medical and nurse practitioner services and explain any misconceptions. The changes implemented from August 2020 include:</p> <p>-Liaising with the GP and NP around care home visits, with both attending to each care home regularly. At The Avenues, the GP and the NP now visit on alternate weeks. Where possible the</p>   | <p>In response to a family complaint, the service has reviewed all applicable documentation in use including the admission agreement to more clearly detail the role of a nurse practitioner, and how this role supports clients with service delivery. The feedback from clients</p> |

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| <p>family/whānau of choice where appropriate, local communities, and referral agencies.</p>  |           | <p>resident/family are encouraged to meet with the NP on admission.</p> <p>-The GP and NP profile is provided to residents on admission and were also distributed to existing residents and family.</p> <p>-The admission agreement was amended to reflect the use of the GP and NP. Clear guidelines in the agreement around when a resident chooses another medical service that there is need for that GP to be contracted with the service to ensure resident reviews and medical needs are provided as per legislative requirements.</p> <p>-Surveys were conducted to measure success of this improvement. The results for March 2021 showed that there were no complains raised in relation to medical and nurse practitioner services provided over the past six months and 100% of the care home residents are using The Avenues contracted medical services.</p>   | <p>and families is positive, there have been no further complaints, and all clients have registered to receive care from The Avenues contracted GP and NP.</p>  |
| <p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p> | <p>CI</p> | <p>Metlifecare promotes no restraint use within its services and this has been effectively delivered as monthly surveillance across the company care homes evidences nil restraint use for over five years. This includes at The Avenues.</p> <p>Despite variations in the number of resident falls reported monthly, which is being addressed in a fall's prevention initiative, the care team have not resorted to using restraint. Instead, a range of individualised strategies have been implemented including ensuring staff are educated and well-trained from orientation onwards on restraint elimination and that this care home is 'restraint free'. Ongoing systematic environmental checks are in place and any potentially unsafe aspect addressed immediately. Family members are informed of the restraint free environment and that there is no use of equipment or support of situations that have the potential to restrain a person or go against their will. This includes use of lap belts or bed rails. Residents right to decline personal cares or activities of daily living was noted, and staff work collaborative within the care team to ensure the residents needs are being met without coercion. An acute confusion screening/assessment tool has been recently introduced and guides registered nurses to consider delirium states and has contributed to the development of guidelines around supervisions and safety with residents with acute confusion (refer to 1.1.8.1)..</p> <p>Measures of review and evaluation have included thorough investigations of all falls, the development of individualised strategies for falls prevention that do not include restraint use and routine review of falls data to identify areas for improvement. Reviews of events for behaviours of concern are undertaken to ensure there is evidence of good practice and preventive processes are considered.</p> <p>Staff interviewed were clear that restraints were not used and that instead individual strategies</p> | <p>Through implementation of a range of supportive and educational processes, the organisation's philosophy and intention to eliminate the use of restraints is being upheld in this facility. Evaluation and review processes confirm effectiveness of the strategies with no restraints having been used since it opened in September 2019. Restraint has not been used in any of the Metlifecare facilities for at least five years.</p> |

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|  |  | <p>were developed and implemented to support resident's safety while optimising independence and freedom of movement and choice.</p> <p>One resident is using enablers (a bed rail and a lap belt). The resident and family member confirmed these devices were initiated and used at the resident's request, to enable the resident to be more independent. A consent form has been completed and other applicable documentation maintained. This is the first resident that has used an abler since The Avenues opened, beginning in June 2021.</p> |  |
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End of the report.