

# McKenzie Healthcare Limited - McKenzie HealthCare

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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 BSI Group New Zealand Ltd, 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:

<b>Legal entity:</b>	McKenzie Healthcare Limited
<b>Premises audited:</b>	McKenzie HealthCare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 27 January 2021      End date: 28 January 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>	60

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

## General overview of the audit

McKenzie HealthCare currently provides hospital (geriatric and medical), rest home and dementia level care for up to 85 residents. On the day of the audit there were 60 residents.

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

The service is managed by a general manager (registered nurse), and a clinical coordinator (registered nurse).

Improvements are required around staff appraisals, care plan interventions and progress notes.

The service has achieved a continued improvement rating around the activities programme.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies are documented to support resident rights. Systems protect their physical privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained.

Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The service is owned and operated by McKenzie Health Care since August 2007. The board consists of a managing director and four directors. A strategic business plan includes the vision, values, and philosophy of care. The general manager is a registered nurse with a current practising certificate who has been working in the aged care area for many years. The clinical coordinator manager is a registered nurse and provides clinical and operational oversight.

There is a documented quality and risk management system. There are a range of policies, procedures, and forms in use to guide practice. Data related to improvement of service delivery is collected. An internal audit schedule is in place with audits completed as per schedule. Adverse events are documented. Corrective action plans are documented when issues are identified.

There is a documented rationale for determining staff levels and staff mix to provide safe service delivery in the dual-purpose rest home and hospital wings and the dementia wing. The base roster provides sufficient and appropriate coverage for the effective delivery of care and support and can be adjusted for support acuity levels.

The human resource management system is documented in policy with recruitment completed as per policy. There is a documented orientation and annual training plan.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Resident files reviewed provide evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate

service integration and are reviewed at least six-monthly. Residents are reviewed at least three-monthly by the general practitioners. There is evidence of other allied health and specialist input into resident care. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. An integrated activities programme is implemented for all residents. The programme includes community visitors and outings, entertainment and activities that meets the recreational preferences and abilities of the residents. All food and baking is done on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. A contracted dietitian reviews the menu plans.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored securely throughout the facility, and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. The building holds a current warrant of fitness. Reactive and preventative maintenance is carried out. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated.

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant. External garden areas are available with suitable pathways, seating and shade 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.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training around management of challenging behaviour. There were two residents using enablers on the day of audit and no restraint in use.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks. Covid-19 guidelines are in place.

## 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>	1	41	0	2	1	0	0
<b>Criteria</b>	1	89	0	2	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>Policies and procedures are in place to ensure resident rights are respected by staff. Staff receive education during orientation and ongoing training on consumer rights is included in the staff annual training plan. Staff interviewed (general manager, clinical coordinator; care staff including four registered nurses, one enrolled nurse and five healthcare assistants; one activities coordinator; one head chef, one kitchen assistant; one cleaner, one laundry assistant and one maintenance officer) were knowledgeable around the Health and Disability Commissioner’s Health and Disability Services Consumers’ Rights (the Code) and could describe how to apply this as part of their everyday practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on eight resident files reviewed (two rest home, three hospital and three dementia). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents’ charts. Dementia resident EPOAs have been activated.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families and is available at the entrance to the service. Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff.</p> <p>Discussions with eight family and six residents identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files included information on resident's family and chosen social networks.</p> <p>A local advocate attends resident forum meetings and a new representative from advocacy services has recently contacted the service to provide ongoing support. The general manager has encouraged Age Concern to visit and talk with residents if they have raised issues or wish to talk with an independent person.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours and family reported that they are encouraged to visit at any time. Residents confirmed that they are supported and encouraged to access community services independently or as part of the planned activities programme. Residents continue to be as independent as possible with activities in the community.</p> <p>The service encourages the community to be a part of the residents' lives in the service with visits from entertainers.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Policy and procedures are in line with Right 10 of the Code and identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints.</p> <p>Complaints management is explained as part of the admission process with the policy and forms included in the information pack given to potential residents and family. Complaint forms include contact details for advocacy services. Residents and family confirmed that they are informed by the manager or clinical coordinator that they can talk with them at any time. Training on the complaints policy and process is part of the staff orientation programme and ongoing education.</p> <p>The complaints register records the complaint and date of resolution with any documentation of the complaint retained in the complaints folder. The complaints register is up to date.</p> <p>There have been six internal complaints since the last audit. All six have been investigated and resolved within timeframes documented in policy. One of these complaints was not completed in the required</p>

		timeframes however taking into account the investigation process and ongoing correspondence, this was managed appropriately. There is evidence complainants were happy with the outcome.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information on the Code and the Nationwide Health and Disability Advocacy Service is displayed in the facility including pamphlets available for residents and family in the dementia unit, rest home and hospital. The service provides information on the Code to families and residents on admission.</p> <p>Residents interviewed (one from the rest home and five from the hospital), and family interviewed (four from the hospital, one rest home and three with family in the dementia unit) stated that they believe their rights were met as per the Code. Information around advocacy services and the Code is discussed with residents and relatives on admission. Residents and relatives interviewed confirmed that the Code and the advocacy services were explained on admission.</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>There are a range of policies and procedures to ensure residents are treated with respect. Staff endeavour to maximise residents' independence by encouraging them to actively engage in cares and to continue to access the community as long as possible. There is respect for residents' spiritual, cultural and other personal needs as confirmed by residents and family interviewed. Residents are referred to by their preferred name as observed on the day of audit. The younger person disabled resident maintains links to the community.</p> <p>The service ensures that each resident has the right to privacy and dignity. Discussions of a private nature are held in the resident's room and there are areas in the facility that can be used for private meetings. Staff reported that they knock on bedroom doors prior to entering rooms and ensure doors are closed when cares are being completed as observed on the day of audit. Verbal handovers and personal discussions are held in private areas as observed during the audit. Residents and families confirmed that physical privacy is respected.</p> <p>Staff stated that they are committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive training annually on abuse and neglect and can describe signs and reporting requirements. Residents personal belongings are not used for communal use. The general practitioner stated that there was no evidence of abuse or neglect. Residents and family interviewed stated that there was no evidence of abuse or neglect.</p> <p>There are quiet, low stimulus areas that provide privacy for residents in the dementia unit.</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>	<p>FA</p>	<p>There are policies and procedures covering cultural safety and cultural responsiveness. The documentation includes appropriate Māori protocols and provides guidelines for staff when supporting residents who identify as Māori. The documentation is referenced to the Treaty of Waitangi and includes guidelines on partnership, protection and participation.</p> <p>Staff interviewed confirmed an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through refresher training.</p> <p>Staff interviewed described how they asked residents and family who identify as Māori, to describe what their needs are. Three records for residents who identify as Māori were reviewed and these identified the resident's cultural needs in their care plans and activity plans. One Māori resident was interviewed and stated his cultural requirements were met.</p> <p>Access to Māori support and advocacy services are available through the DHB if required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan. Staff interviewed confirmed their understanding of cultural safety in relation to care. Residents and family members interviewed confirmed that staff respect their values and beliefs.</p> <p>Care staff interviewed could describe how they communicate by using signs and body language for residents who have difficulty communicating due to dementia, or residents who have English as a second language. Local interpreters are available from the DHB. Interpreting services are available. A number of staff also have a second language and communicate to residents if required in their own language.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in policy and job descriptions. Staff sign a confidentiality clause and house rules on employment.</p> <p>Staff interviewed demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and relatives reported that staff maintain appropriate professional boundaries, including the boundaries of the care partner role and responsibilities.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are policies and procedures to guide practice. These align with the Health and Disability Services Standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals by an external aged care consultant. Clinical staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice with this able to be described by clinical staff.</p> <p>The education programme includes mandatory training requirements for staff and other significant clinical aspects of care delivery. A staff educator is employed three days a week and ensures all staff complete orientation requirements and compulsory education.</p> <p>Family members interviewed confirmed they are satisfied with the care provided. Residents were happy with all aspects of care.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There are policies covering communication with residents/relatives, and management interviewed, reported that they have an open-door policy. Information is provided in a manner that the resident can understand. Relatives and residents can discuss issues at any time with staff.</p> <p>The incident and accident forms include an area to document if the relatives have been contacted. Twelve incident forms reviewed identified family were informed where required. Open disclosure is practised and documented when family are contacted. The general practitioner interviewed, reported satisfaction with communication from staff.</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>McKenzie HealthCare is certified to provide rest home, dementia level care and hospital (geriatric and medical) for up to 85 residents.</p> <p>Of the 85 beds identified as being certified, 13 dual purpose beds are for residents living in the independent unit, 18 identified as being for residents with dementia requiring a secure unit and 54 as available for residents requiring hospital (dual purpose) level of care. On the days of the audit, there were 60 residents including ten requiring rest home level of care (including one resident funded under a respite contract); 39 requiring hospital level of care (including one resident funded under a younger persons disabled contract (YPD) and 11 requiring dementia level of care.</p> <p>McKenzie HealthCare is privately owned by a managing director and three associate directors who maintain regular contact. The current general manager is a registered nurse (RN) who has been in the role for 20 months and has extensive experience in overall clinical and operational management. She is supported by a clinical coordinator, who is an experienced registered nurse and has been in the role for one year and has worked at the facility for ten years.</p>

		<p>The mission statement and philosophy of care are documented and given to any potential or new resident and/or family on admission to the service as part of the welcome pack. The 2020- 2023 strategic plan has been circulated in December awaiting approval at the next board meeting in early March 2021. The 2017 - 2020 plan was reviewed in December 2020.</p> <p>The management team have completed at least eight hours of professional development, related to managing an aged care residential facility including completing dementia specific training.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the temporary absence of the general manager, the clinical coordinator is able to take responsibility for the service and provide both clinical and operational management. Senior registered nurses provide cover for the clinical leader when on leave. The manager is on call Monday to Friday and every fourth weekend. The senior nurses share the weekend on call rotating every four weeks.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a quality and risk management framework that is documented to guide practice. The service implements organisational policies and procedures to support service delivery. All policies are subject to review by the external aged care consultant, with input from the general manager and clinical leader. Policies are linked to the Health and Disability Services Standards, current and applicable legislation, and evidence-based best practice guidelines. Policies are available to staff in hard copy. A document control system is implemented, and this ensures that documents are approved, up-to-date, and managed to preclude the use of obsolete documents. A computer attack has resulted in the loss of some electronic documentation, however all on site policies have been reviewed and updated.</p> <p>Service delivery is monitored through review and resolution of complaints; review of incidents and accidents; surveillance of infections; monitoring for any pressure injuries; feedback from residents and family and implementation of an internal audit programme. The internal audit schedule is documented annually with audits completed as per schedule. Corrective action plans have been developed for results less than expected and signed off when completed.</p> <p>The schedule of quality/staff and registered nurse meetings documents discussion and review of data. Staff reported that they are kept informed of quality improvement and risk management through meetings. Resident forum meetings are held three-monthly to allow for discussion around quality improvement data. A survey was last completed in August 2020. Opportunities for improvement identified through analysis of</p>

		<p>the survey results were identified and acted on.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented and align with new legislation. There is a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards including any maintenance issues are addressed as soon as they arise, and risks are eliminated, minimised or isolated. Health and safety is audited monthly. Review of incidents, risks, accidents, and clinical issues are discussed through quality/staff meetings as part of the health and safety programme.</p> <p>The 2020 quality plan has been implemented and the 2021 plan commenced.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that incidents and accidents are being reported with these signed off by the manager or clinical coordinator.</p> <p>Twelve incident forms were reviewed, and these showed evidence of immediate responses, investigations and remedial actions being implemented as required. This includes reporting to family members and informing the general practitioner when incidents occur. Both family and the general practitioner interviewed confirmed that incidents are reported in a timely manner. The sample confirmed that incidents and accidents are closed following review and linked to the quality system with documentation of data at relevant meetings. Neurological observations are documented for a fall with a head injury or an unwitnessed fall.</p> <p>The manager could describe the statutory and/or regulatory obligations in relation to essential notification reporting and could describe the process of notification to the correct authority where required. Three section 31 notifications have been sent to HealthCERT since the previous audit. The notifications are for a stage three pressure injury, RN staffing and one advising of a computer system attack.</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>	PA Low	<p>There is an established system in place for human resource management. Staff records reviewed (clinical coordinator, two registered nurses, four healthcare assistants, a cook and one activities coordinator) included an employment agreement and a position description. Reference checks are completed for new staff. Staff have criminal vetting prior to appointment and professional qualifications are validated. All staff receive an orientation with a record of this maintained on staff files reviewed. The orientation programme covers key aspects of the organisation and service delivery including special care requirements for hospital, dementia, and rest home levels of care. A physiotherapist provides additional education on manual handling, lifting and hoist use as required. One new healthcare assistant was interviewed and stated that they had completed a comprehensive orientation with a buddy system operating. There is a</p>

		<p>schedule for staff annual performance appraisals, however not all appraisals have been completed as scheduled.</p> <p>The 2020 training plan was implemented with a high number of care staff attending training sessions. All healthcare assistants are required to complete manual handling sessions annually. Staff complete competencies relevant to their role such as fire safety, infection control, restraint, challenging behaviour and medications.</p> <p>There are 22 healthcare assistants who work in the dementia unit. Twenty have completed training in dementia care and two are in training. A review of rosters for the past four weeks confirmed that there was always an HCA trained in dementia care on duty in the dementia unit.</p> <p>Eleven of thirteen registered nurses including the clinical coordinator and manager are interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The process for determining provider levels and skill mix is defined in policy and considers the layout of the facility and levels of care provided. Staff rosters are developed by the general manager. The service uses casual or existing part time staff to relieve for staff who are on planned leave. As a result of higher than normal unexpected leave (three staff on ACC) and resignations, it has not always been possible to fill all recent HCA rosters. Staff interviewed confirmed that management and registered nurses provide assistance when short staffed. Management are actively recruiting for both permanent and casual staff to assist.</p> <p>The general manager provides afterhours on call during weekdays, and weekends rotations are covered by senior registered nurses. Staff stated that on call staff respond promptly. Two registered nurses work 8 hour shifts in both the North and South wings on morning and afternoon shifts. One RN is rostered on night shift with a second on five out of seven nights. The service is recruiting to fill the other two nights.</p> <p>Rosters are split across three areas. North includes Willow, Beech, Smith wings and part of the Manuka wings with a total of 30 residents (5 rest home, 25 hospital). Healthcare assistants are allocated to each area. South includes Kauri, Birches and part of Manuka wings with 19 residents (17 hospital and two rest home). Allocations are regularly reviewed according to resident acuity.</p> <p>South units are staffed as follows: morning two HCAs from 6.45 am to 3 pm and two from 7 am to 1.30 pm, afternoons one HCA from 3 pm to 11 pm, one 3 pm to 9 pm, and one 4.30 pm to 9 pm and two night HCAs from 11 pm to 7 am.</p> <p>North units are staffed as follows: morning two HCAs from 6.45 am to 3 pm and two from 7 am to 1.30 pm plus a float shift from 7 am to 1.30 pm, afternoons one HCA from 3 pm to 11 pm, one 3 pm to 9 pm, and one 4.30 pm to 9 pm and one night shift or two if an RN is not rostered.</p> <p>The Pines unit (dementia) unit with 11 residents is staffed in the morning by an enrolled nurse from 7.30</p>



		<p>am to 4 pm Monday to Friday, an HCA from 6.45 am to 3 pm and a recent addition of a 7 am to 1.30 pm. A second HCA is rostered to work weekend morning shifts from 6.45 am to 3 pm. Afternoon shifts are covered by two HCAs working from 2.45 pm to 11 pm and a new shift of 4.30 pm to 9.30 pm. One HCA is rostered overnight (from 11 pm to 7 am) with assistance from the float position working between North wing and the Pines.</p> <p>The registered nurse is rostered to work in the hospital unit and completes resident rounds of the dementia unit and rest home each shift, sees residents of concern and attends handovers.</p> <p>A diversional therapist oversees a team of two activities assistants. The activities assistant based in the dementia unit has commenced her dementia specific NZQA qualifications. There are separate cleaning and laundry staff employed.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Resident records are integrated. Resident records in use are maintained confidentially electronically and paper documentation is locked in a secure area when not in use. Progress records are documented by the care staff in the electronic system (link 1.3.5.2). The date, time, signatures, and designation of those entering into the records is legible.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Residents are assessed prior to entry to the service by the needs assessment (NASc) team, and an initial assessment with an interRAI assessment completed on admission. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. There is specific information provided for families regarding dementia care and palliative care provided. The three dementia residents whose files were sampled had NASc approval for the service and EPOA activation letters on file. All admission agreements reviewed (for long-term residents and respite resident) aligned with all contractual requirements. Exclusions from the service are included in the admission agreement. A total of eight signed admission agreements were sighted. Family members interviewed agreed the staff had fully explained services to them on entry to services. The provider was given the opportunity to address and correct the admission agreement to align with recent ARRC variations to clause A13 regarding premium room charges.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The transfer/discharge/exit procedures include a transfer/discharge form, and the completed form is placed on file. The service stated that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation are forwarded with the resident. Hospital discharge documentation is uploaded to the Leecare system.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Sixteen medication charts were reviewed on the Medi-Map electronic system. Medication management is implemented using an electronic system and blister packs from a contracted pharmacy. All aspects of medication management are in line with best practise. Medications are delivered to the facility monthly and checked against the electronic prescription and signed by an RN. Input is available from the pharmacist on request. Medication errors are completed on an incident form on Leecare. There is an updated medication policy. There are no standing orders in use.</p> <p>Controlled drugs are stored securely in a locked cupboard and always checked by two medication competent staff. The controlled drug register showed evidence of accurate stocktake entries. Administration entries in the controlled drug register are fully completed at every entry. Specimen signatures were sighted and updated six-monthly. Non-packaged medications were stored in a locked cupboard and showed evidence of stock rotation. All medications sighted were within the recommended use by dates. Medication fridge temperatures and medication room temperatures were recorded daily. Storage systems for medicines are locked within rooms with restricted entry and include one room in the dementia wing.</p> <p>Good prescribing practices were noted on the electronic medication management system. The reasons for Pro Re Nata (PRN) medications met the required standard. The requirement for three monthly review by a GP was met and due dates consistently recorded on the medication chart.</p> <p>At the time of audit there were no residents who were self-administering their medications. The RNs, enrolled nurse and senior HCAs administering medications undergo an annual medication competency. Registered nurses have current syringe driver competencies.</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</p>	<p>FA</p>	<p>There is a food services policy and procedure manual. All food is cooked on site. A dietitian has reviewed and approved the menu. All residents have a dietary requirements/food and fluid chart completed on admission. The chef maintains a folder of residents' dietary requirements that includes likes/dislikes. Alternatives are offered, and alternatives are provided as needed. Specialised utensils and lip plates are available as required. Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternatives offered. Fridge and freezer temperatures are recorded daily and calibrated according to good</p>

<p>component of service delivery.</p>		<p>practice. Perishable foods in the chiller and refrigerators are date labelled and stored correctly. The kitchen is clean and has a good workflow. The kitchen was refurbished in December 2019. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons, and gloves. There is a verified food control plan.</p> <p>Chemicals are stored safely, and safety datasheets are available. The service has a second option at lunch and teatime. Residents commented positively on the food and options available. The chef interviewed explained the communication between the kitchen and care staff and their involvement in management of residents' weight loss and the nutritional needs of residents in the dementia wing. Snacks are available for all residents over 24 hours including the residents in the dementia wing. Food is transported by hot boxes to the servery areas. Food temperatures are recorded.</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 the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry if this occurs. Potential residents are then referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RN completes an initial assessment on admission including risk assessment tools as appropriate on Leecare. An interRAI assessment is undertaken within 21 days of admission and six-monthly. One resident had an earlier interRAI assessment completed due to recent health changes and prior transfer to the dementia unit. The provider completed a recent internal audit with 100% compliance interRAI result. Resident needs and supports are identified through the ongoing assessment process and form the basis of the long-term care plan. The respite care resident had an initial assessment and applicable risk assessments completed. Ongoing assessments are completed on Leecare and is auto populated into the progress notes.</p> <p>There were regular pain assessments evident for the resident on palliative care.</p> <p>Residents interviewed confirmed their preferences and choice are accommodated during their care journey.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>Seven residents' long-term care plans (a young person with disability and a resident receiving end of life support) were reviewed on the resident electronic system.</p> <p>Two files (one hospital and one rest home) did not have care interventions detailed enough to meet their individual needs. Assessment outcomes were included in the long-term care plans reviewed. The Leecare system identifies interventions that cover a set of goals including managing medical needs/risks.</p> <p>Alerts on the resident's electronic home page identify current and acute needs such as (but not limited to); current infection, wound or falls risk. Short-term needs are added to the long-term care plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. The three dementia care resident files reviewed had 24-hour activity plans with documented behaviours, triggers, and activities to distract and de-escalate behaviours. The long-term care included a detailed behaviour management plan.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian, and a dental nurse. One hospital resident had a specific 'End of Life' care plan in place following a change in health status. The contracted physiotherapist reviews residents transfer plans. Medical GP, nurse practitioner notes and allied health professional progress notes were evident in the residents' integrated electronic files sampled. Any change in care required is documented and verbally passed on to relevant staff.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observation, and interview with the registered nurses verified that care provided to the residents was consistent with their needs, goals and plan of care. The interview with the GP confirmed that discussion and referral to allied health professionals took place in a timely manner. When medical input was required, he was notified promptly, and any medical orders were appropriately carried out. Family/whānau expressed during interview that assistance was given according to the wishes of their relatives. Specialised equipment including hoists, transfer belts, pressure relieving mattresses and cushions were available for use. Continence and wound care products were in stock for use.</p> <p>The wound register was reviewed and current; an updated wound care policy including PI management, and management of skin, nutrition and hydration needs were reviewed. Wound assessment and wound management plans were in place on Leecare for seventeen residents (across services) including one Stage 2 PI, three Stage 1 PIs, 6 skin tears, two basal cell carcinoma lesions, three leg ulcers and two skin conditions. Two residents had more than one wound, each wound has its own assessment and management plan. Interventions were undertaken in the stated timeframes by the RN or EN. The ulcers were all included in the resident's long-term care plans. Registered nurses interviewed were aware of when and how to get specialist wound advice and the in-house wound nurse specialists are involved in</p>

		<p>the care of chronic ulcers.</p> <p>Monitoring records for (but not limited to) weight, food and fluids, blood sugars, regular turns, behaviours, and routine observations including neurological observations after unwitnessed falls demonstrates that appropriate cares are occurring. The medical needs of YPD and a resident on end-of-life care were comprehensively described and interviews and observations confirmed these are met.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>McKenzie HealthCare employs three activity staff (one diversional therapist and two activities assistants) who are responsible for the planning and delivery of the individual and group activities programme with assistance from healthcare assistants. The weekly planner is posted on the noticeboard, activities include (but not limited to) exercises, or a group game in the morning and craft, ball and balloon games, quiz, sing-a-longs, and exercises in the afternoons. HCAs provide activities over the weekend including movies. Dementia-specific activities included (but are not limited to) communal sing-a-longs and dancing, ball games, art and craft and gardening. There are seven active volunteers assisting with various activities throughout the month including walking groups and to accompany one resident (young person with disability) to community involvement activities. The activities staff have one-on-one time with residents who are unable or who choose not to participate in the programme.</p> <p>Information such as a social history, previous hobbies and preferences is gained from relatives on or soon after admission. This information is then used to develop a diversional therapy plan on Leecare, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process. Progress notes are maintained by the diversional therapist. Residents have 24-hour activity plans incorporated in their care plans. Group activities are provided in the large communal dining room and lounge, and in seating areas and outdoors in the gardens when weather permits. Individual activities are provided in residents' rooms or wherever applicable.</p> <p>Special events like birthdays are celebrated with all residents. The event is celebrated, and photos of the resident are taken and send to family that could not attend, the photos are displayed in the resident's room. Other events have included Christmas and mid-winter Christmas celebrations.</p> <p>The activity hours are planned to be increased once occupancy increased. Diversional therapy input on a Saturday morning is being considered. The service receives feedback and suggestions for the programme through resident focus meetings, six monthly family meetings and an annual survey.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	FA	<p>Care plans reviewed were updated as changes were noted. Care plan evaluations were reviewed in six of eight care plans that had been at McKenzie Healthcare for six months or longer and reflected progress against the documented goals.</p>

comprehensive and timely manner.		
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents and/or their family/whānau are involved as appropriate when referral to another service occurs.
<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	There are policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording, and reporting all incidents on Leecare. Chemical supplies are kept in locked cupboards in the hospital, rest home and dementia units. A contracted supplier provides the chemicals, safety datasheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment is readily available to staff and enough supplies are available in the event of management of an outbreak
<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>The building holds a current building warrant of fitness that expires 1 July 2021 and a certificate for public use (CPU) that expires 1 February 2021. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. The service employs a full-time maintenance person that holds a trade certificate who carries out minor repairs and maintenance. The maintenance request book is checked and signed off as requests are actioned. Electrical equipment is tested and tagged. Contractors are available for essential services. Clinical equipment is calibrated annually. The maintenance person checks hot water temperatures and undertakes monthly maintenance audits.</p> <p>The corridors are carpeted, and other flooring is appropriate for the service provided. Corridors are wide and there are handrails in all corridors which promotes safe mobility. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>There are external areas and gardens, which are easily accessible (including wheelchairs) and safe</p>

		<p>access. There is outdoor furniture and seating, and shaded areas. There are adequate storage areas for the hoist, wheelchairs, products and other equipment. The staff interviewed stated that they have all the equipment referred to in care plans to provide care. The facility is smoke free.</p> <p>The secure dementia unit has a secure garden area which is freely accessible from both dining/lounge areas and includes outdoor furniture and seating and shaded areas. The garden has paths with loops and areas of interest. The facility continues to improve the outdoor area off the dementia wing and are planning to extend the path by removing part of the fence, completion is planned for July 2021. The outdoor area is partly accessible from the second dining/lounge area for residents until landscaping is completed in this area. In the meantime, they have safe access to the current secure outdoor garden and outdoor balcony area.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All dual-purpose rooms except ten have access to shared ensuites. There are four bathrooms for the ten rooms without ensuites to share.</p> <p>There is a mixture of twelve shared and six single ensuite facilities in the dementia unit. There are privacy curtains in place, with indicators to show if the toilet is in use to maintain privacy. Toilets are located close to communal areas.</p> <p>Residents in 13 care apartments all have their own toilet and shower. There were no residents in the serviced apartments on the day of the audit that receive care input.</p> <p>There were communal toilets located close to the communal areas. Toilets have privacy locks. There is a mobility bathroom in the dual-purpose unit with shower chairs.</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>All resident rooms in the facility are single. The resident rooms allow the residents to move about independently with the use of mobility aids. The resident rooms and all apartments have doors wide enough to accommodate mobility aids and equipment. Residents and their families are encouraged to personalise the bedrooms as sighted. Residents interviewed, confirmed their bedrooms are spacious and they can personalise them as they wish.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with</p>	FA	<p>All areas (rest home/hospital, dementia unit and serviced apartments) have a separate dining area and lounge. Additionally, there are several smaller areas to create a more home-like environment. Seating is placed appropriately to allow for groups and individuals to relax or take part in activities. There is a small library, and a large community room to accommodate facility events. The wide corridors are light and spacious. Residents were observed safely moving between the communal areas with the use of their</p>

<p>safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>mobility aids. There is adequate space to allow for individual and group activities to occur.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All personal clothing is laundered on site. An external provider launders and provides bed linen three times a week. Adequate linen supplies were sighted. There are cleaners on duty each day for the facility. The cleaners' chemical cupboards are locked. All chemicals have manufacturer labels. The cleaning trolley is well equipped and stored in a locked area when not in use. Cleaning staff were observed to be wearing appropriate personal protective equipment. The environment on the day of audit was clean and tidy in all areas. The residents interviewed are satisfied with the cleanliness of the communal areas and their bedrooms.</p> <p>The facility has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits were completed as per the internal audit programme. The laundry has an entry and exit door with defined clean/dirty areas. The service has a secure area for the storage of cleaning and laundry chemicals for the laundry. There are dedicated cleaning and laundry persons on duty each day.</p> <p>Residents interviewed stated they were happy with the cleanliness of their bedrooms and communal areas. Residents also confirmed their clothing was treated with care and returned to them in a timely manner.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an approved evacuation scheme. Evacuation drills occur at least six-monthly, with the results of these documented. There is a staff member on duty 24/7 with a current first aid certificate.</p> <p>In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare batteries for lights, a gas barbecue, linen, continence products, torches and batteries, water, and blankets. Food dry stock and frozen food are available to support residents for at least three days. There is enough drinking water on site to support the maximum number of residents on site for three plus days.</p> <p>A modern call bell system was installed August 2019 in all resident rooms, communal areas, and toilet/shower facilities. The electronic call bell system is monitored by the company and has an emergency battery backup. Call bell alert modifications are being implemented to limit notifications to separate pagers across the three areas. Pagers are carried by all healthcare assistants and RNs and are activated throughout the facility.</p> <p>Closed circuit television has been installed in external areas. These can be monitored to ensure safety of</p>



		<p>residents. The two entrances to the dementia unit are secured with keypad entry. A perimeter fence around the dementia unit with locked gates ensures residents are kept safe.</p> <p>Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed appropriately and doors are locked appropriately. External doors are locked in the evening. The main door is locked and opened automatically by timer. There is external lighting. There is an arrangement with the local police station to assist with security concerns.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows with plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>There are clear policies and procedures for infection, prevention and control which minimises any risk of infection to residents, staff, and visitors. Infection control management is appropriate to the size and scope of the facility.</p> <p>There is an infection control coordinator (registered nurse) who is responsible for infection control across the facility. The coordinator liaises with and reports to the manager. The responsibility for infection control is described in the job description. The coordinator collates monthly infection events and reports. The infection control programme is reviewed annually by the IC coordinator and the manager.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks.</p> <p>There are clear guidelines for staff and residents around Covid-19. Changes are communicated to staff at handovers and through written news bulletins. Staff have to sign when they have read the bulletins.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p>	FA	<p>The IC coordinator is a very experienced registered nurse, and the facility has access to infection control expertise within the district health board. This includes access to the wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics.</p>

physical, and information resources to implement the infection control programme and meet the needs of the organisation.		
<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	The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies were developed by an external infection control specialist.
<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	The IC coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have participated in IC education in the last year and there is more training planned for 2021. There was particular emphasis on hygiene and personal protective equipment (PPE) during Covid-19 lockdown. Resident education occurs as part of providing daily cares and as applicable at resident meetings.
<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>The infection control coordinator is responsible for the surveillance programme of infections. Standard definitions, types of infections are documented to guide staff. Information is collated monthly and clearly documented in the infection log maintained by the infection control coordinator. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Infections are investigated, and appropriate plans of action were sighted in meeting minutes. The surveillance results, trends and analysis are discussed at the staff and registered nurse meetings. Monthly data is benchmarked (by the aged care consultant) with reports and graphs generated for the service. Infection control data is discussed with management and staff. Corrective actions are developed for any areas of concern. The outcomes of surveillance are used to identify areas for improvement and training</p>

		<p>needs for the service. Internal audits have been conducted and included hand hygiene and infection control practices.</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>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>McKenzie HealthCare has policies and procedures around restraint minimisation and safe practice that have been developed by an aged care consultant and reviewed in line with the policy. Care staff interviewed stated that there is a focus on minimising the use of restraint. There were no residents using restraints. Two residents had requested the use of bedrails and one a lap belt and all were documented as enablers.</p> <p>Staff receive annual training on restraint minimisation and safe practice and complete competency questionnaires. The staff educator provided training on challenging behaviours in August 2019 and there has been further training for staff in October 2020.</p>

## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	McKenzie has a policy where all staff have performance appraisals annually. The service has a corrective action in place to schedule outstanding appraisals which is being implemented. Five of nine staff files reviewed had a current performance appraisal.	Four of nine staff files did not have current performance appraisals.	<p>Ensure all staff have a current performance appraisal.</p> <p>90 days</p>
Criterion 1.3.3.4	PA Moderate	The RNs are responsible for reviewing residents following changes in health, adverse events and in conjunction with GP visits and documenting in the	Three files (two from the dementia unit and	Ensure documentation

<p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>		<p>resident progress notes.</p> <p>The provider uses Leecare electronic system. There is an updated clinical documentation policy that stated, "Registered nurse entries should reflect a summary of care givers` notes". Medication administration, assessments, documented daily care charts and incident reports and RN follow-up are auto populated in the system as progress notes. The RNs are responsible for reviewing residents following changes in health, adverse events and in conjunction with GP visits and documenting in the resident progress notes. The RNs interviewed stated residents are reviewed regularly, however where residents do not require daily input from a RN there is inconsistent evidence in the progress notes that the RNs contribute to the evaluation of care provided by the HCAs and EN.</p>	<p>one rest home resident) of the eight files reviewed did not evidence regular contribution to care by a registered nurse.</p>	<p>evidences that RNs contribute to care by evaluating progress notes of the HCAs and EN for all residents in the rest home and dementia unit.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Low</p>	<p>Seven long-term care plans were reviewed on the electronic Leecare system. A variety of assessment tools formed the basis of the long-term care plan, individual goals, and expected outcomes. Healthcare assistants and RNs interviewed confirmed they have knowledge of all residents' needs. Care plans did not always reflect the detailed interventions required to support identified issues and to guide staff.</p> <p>Short-term needs were integrated into the care plans.</p> <p>The family members and residents interviewed reported that they were happy with the care provided and the communication they received.</p>	<p>Two care plans reviewed (one hospital and one rest home) did not provide sufficient interventions to guide staff in the care of a resident with a colostomy and risk of recurrent UTIs and a resident with episodes of faecal incontinence.</p>	<p>Ensure interventions are resident-focussed to guide staff in the management of the care.</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 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The activities team have embedded a resident focused activity programme that is inclusive of all residents across the service. In response to resident-initiated activities and involvement in many aspects of the service, the resident’s satisfaction with the activities programme is evidenced by attendance and resident group involvement. The respite resident confirmed that the activities programme is the reason for her return to the facility. The local Kaumatua and one resident affiliated with Maori were interviewed and confirmed activities are cultural appropriate and inclusive. Residents are a part of all decision-making processes and evident in the resident focussed meetings and resident attendance numbers.</p> <p>McKenzie Healthcare developed a quality initiative aiming to increase inclusiveness and participation in the activities of all residents across all services during COVID-19 lockdown levels. The project was initiated as a result of resident feedback during resident focussed meetings. Two projects</p>	<p>McKenzie Healthcare has implemented an activities programme that is meaningful and varied for the residents. The programme allows residents to maintain strengths and skills, maintain connections with the community and experience events they could otherwise not access. As examples this has included quality improvements to enable community engagement through initiatives that improve inclusiveness and participation of residents across the service. The depth and breadth of activities seen in the McKenzie Healthcare activities programme exceeds that expected for full attainment of this criteria.</p>

		<p>reviewed (“Learn from your elders” and “Community hands”) and discussed on site:</p> <p>1. Learn from your elders.</p> <p>The project aimed to give residents a voice outside the facility and to bridge the gap between generations.</p> <p>Residents were encouraged to make statements on business advice, relationship advice and life advice for young adults. These statements were collated as a PowerPoint presentation for Geraldine High school and presented for International Youth Day. The team included the two diversional therapists (one recently retired) and an activity assistant. Registered nurses and HCAs were involved to assist to write residents` statements on posters.</p> <p>This project commenced during COVID- 19 lockdown and continued to end of July 2020. The presentation was done on 12 August for International youth day and a letter was received from the principal to express how grateful the students were for the advice give. The feedback from residents and staff were positive and showed the value of community connections, residents also expressed that they felt valued as a result of this initiative.</p> <p>2. Community hands.</p> <p>The project aims to include staff, their families, all residents across the service and relatives to collectively create memories on a wall that was to be removed during the last stages of the new built. Events were created where all had a chance to put a handprint and personal message on the wall. The wall was eventually removed and was part of the Geraldine Christmas Parade at the end of 2020. This was valued by both staff, residents and families.</p> <p>Residents interviewed express their excitement around their involvement with the activities. Resident satisfaction survey was completed in August 2020 with an overall 84% satisfaction in the activities provided. This was an improvement in residents` satisfaction and comments from the previous year`s</p>	
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End of the report.