

The Ultimate Care Group Limited - Rose Court Lifecare

Current Status: 14 January 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Rose Court Lifecare provides rest home and hospital level care for up to 75 residents in single bedrooms and studio units. There are 59 residents in Rose Court Lifecare on the day of this audit. The Rose Court Lifecare complex includes a mix of single bedroom apartments and studio units. The facility is operated by The Ultimate Care Group Limited.

This audit includes a review of the six aspects of service provision identified as requiring improvement in the previous certification audit in July 2012, all of which have been addressed.

Two new areas requiring improvement have been identified during this audit relating to the currency of competencies for staff and management of aspects of the food service.

Audit Summary as at 14 January 2014

Standards have been assessed and summarised below:

Key

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
	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

Consumer Rights as at 14 January 2014

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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Organisational Management as at 14 January 2014

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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Continuum of Service Delivery as at 14 January 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 14 January 2014

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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Restraint Minimisation and Safe Practice as at 14 January 2014

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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Infection Prevention and Control as at 14 January 2014

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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HealthCERT Aged Residential Care Audit Report (version 3.91)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	The Ultimate Care Group Limited		
Certificate name:	The Ultimate Care Group Limited		
Designated Auditing Agency:	DAA Group Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Rose Court Lifecare		
Services audited:	Medical and Geriatric Hospital. Rest Home.		
Dates of audit:	Start date: 14 January 2014	End date: 14 January 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			59

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	6
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	4.5
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	16	Total audit hours off site	12.5	Total audit hours	28.5
Number of residents interviewed	6	Number of staff interviewed	11	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	8	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	55	Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX Managing Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of the DAA	Yes
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	the DAA has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	the DAA has provided all the information that is relevant to the audit	Yes
h)	the DAA has finished editing the document.	Yes

Dated Tuesday, 28 January 2014

Executive Summary of Audit

General Overview

Rose Court Lifecare provides rest home and hospital level care for up to 75 residents in single bedrooms and studio units. There are 59 residents in Rose Court Lifecare on the day of this audit. The Rose Court Lifecare complex includes a mix of single bedroom apartments and studio units. The facility is operated by The Ultimate Care Group Limited.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the district health board contract. This audit includes a review of the six aspects of service provision identified as requiring improvement in the previous certification audit in July 2012, all of which have been addressed. Two new areas requiring improvement have been identified during this audit relating to the currency of competencies for staff and management of aspects of the food service.

Outcome 1.1: Consumer Rights

Residents interviewed report that services are provided in a manner that respects residents' rights and facilitates informed choice. Residents interviewed state they are happy with the service provided and report that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and of any significant change in a resident's condition. Visual inspection provides evidence that the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is displayed along with complaint forms.

The facility manager is responsible for complaints and a complaints register is maintained. The residents and their family members can use the complaints issues forms or raise issues at the residents' two monthly meetings.

Outcome 1.2: Organisational Management

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Rose Court Lifecare. Planning documents reviewed include a vision statement, and core values for the service. Systems are in place for monitoring the service provided at Rose Court Lifecare, including regular monthly reporting by the facility manager to The Ultimate Care Group head office. The facility is managed by a suitably qualified and experienced facility manager who is a registered nurse with extensive aged care experience. The facility manager is supported by a clinical services manager/registered nurse who is responsible for oversight of clinical care provided.

The Ultimate Care Group quality and risk management systems are imbedded at Rose Court Lifecare. There is evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. There is an internal audit programme in place. Risks are identified, and there is a hazard register that identifies health & safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Adverse events are documented on accident/incident forms and an electronic database, that is able to be reviewed by personnel from the Ultimate Care Group Head Office. The two areas identified as requiring improvement during the last audit relating to quality and risk management documentation have been addressed.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses (RN), enrolled nurses (EN), the pharmacist, dietitian, and general practitioners (GPs) is occurring. There is evidence available indicating staff are rostered to attend one full study day each year. Inservice education is also provided for staff at least once a month to supplement the study days. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards through the Aged Care Education (ACE) modules. Review of staff records provides evidence of human resources processes being followed and

individual education records are maintained. Improvements are required related to the completion of some of the competency assessments for some staff.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of one registered nurse and two caregivers. The facility manager, clinical service manager or a senior registered nurse are on call after hours. All care staff interviewed report there is adequate staff available.

Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable. This is an improvement since the previous audit.

Outcome 1.3: Continuum of Service Delivery

The registered nurses develop, review, update and evaluate residents' care plans at least three monthly. Residents or their family have input into the development and review of care plans. Residents interviewed are very satisfied with the standard of care provided by staff. Areas requiring improvement identified at the last audit relating to timeframes not met for the initial general practitioner visit and risk assessments not being completed have been addressed.

There is an activities programme suitable for the resident groups residing in Rose Court and some residents carry out their own activities. The two activity officers provide both group and one-to-one activities. Residents interviewed report the programme is varied and they can choose what they would like to participate in.

An appropriate medicine management system is implemented with policies and procedures clearly detailing service providers' responsibilities. Medication files reviewed provide evidence of documented three monthly medication reviews completed by the general practitioners. Weekly and six monthly checks of controlled drugs are completed. The area requiring improvement identified at the last audit relating to the management of self-administration of medicines is no longer an issue. Rose Court policy is not to support the self-administering of medicines. A visual inspection of the medication systems evidence compliance with legislation, regulations and guidelines. There is an area requiring improvement identified at this audit relating to the competency of staff that are responsible for management of medicines.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. A satisfaction survey completed in October 2013, review of residents' meeting minutes, and interview of residents, indicates satisfaction with the quality of the food service provided. Residents also confirm that adequate fluids are provided and snacks are available between meals. Improvements are required to some aspects of food service management.

Outcome 1.4: Safe and Appropriate Environment

Bedrooms provide single accommodation and have full ensuite facilities. There is an adequate number of toilet and shower facilities throughout the facility. Residents' rooms are large enough to allow for the safe use of mobility aids and lifting aids. There are separate lounges and dining areas throughout the facility as well as a large recreation area. Multiple external areas are available for sitting and shading is provided in external areas. An appropriate call bell system is available and security systems are in place.

There are policies and procedures for emergency management and these are known by staff. Staff receive training and education in emergency

management and there is at least one person on each shift with a current first aid certificate. Review of documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment is safe and facilities are fit for their purpose.

Outcome 2: Restraint Minimisation and Safe Practice

There are currently two residents using an enabler and no residents using restraint. Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrate residents are experiencing services that are the least restrictive.

Outcome 3: Infection Prevention and Control

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Review of documentation at Rose Court provides evidence the surveillance reporting process in place is applicable to the size and complexity of the organisation. Results of surveillance are reported on The Ultimate Care Group Limited electronic database and are collated and reported to the monthly quality/staff/infection control/health and safety meetings and via the weekly and monthly reports to The Ultimate Care Group. Staff interviewed report this information is available for them.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	16	0	2	0	0	0
Criteria	0	39	0	1	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	32
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	Competency assessments are not current for all staff involved in medicine management. Not all staff have completed current hand hygiene and manual handling competency assessments.	Provide documented evidence that all staff have completed the appropriate competency assessments and that these are completed on a regular basis.	90
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	(i) Vinyl flooring has a large crack through the middle and where the vinyl is covered up under the cupboards. (ii) Dry goods are not being dated when they are decanted in to other containers. (iii) Kitchen staff are not documenting dates on the cleaning schedule to indicate the date the cleaning has been completed. (iv) There is no documented evidence available to indicate that fridge temperatures are being monitored in the fridges in the hospital and apartment kitchenettes.	Provide confirmation that: (i) the vinyl flooring has been replaced/repared; (ii) the date the dry goods are decanted is being recorded on the containers these dry goods are decanted in to; (iii) kitchen staff are recording the date the cleaning is completed; and (iv) fridge temperatures are being monitored and documented in the fridges in the hospital and apartment kitchenettes.	60

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

Open disclosure procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files reviewed (three rest home and two hospital) provides evidence that communication with family is being documented in residents' records in 'Family/Whanau Communication Record' and in resident's progress notes. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, and in the individual resident's files. Meetings with family are held if there are concerns - minutes sighted in residents' files.

Residents interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care. The facility manager (FM) advises access to interpreter services is available if required via the DHB and interpreter services.

The ARC requirements are met.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Attainment and Risk: FA
Evidence: <p>The service has appropriate systems in place to manage the complaints processes. A complaints register is maintained at the facility and there are 23 complaints recorded for 2013 and one for 2014. A complaints register is also maintained at The Ultimate Care Group (UCG) head office for complaints that are escalated up to them (not reviewed during this audit). Reporting of complaints occurs via monthly meetings and via the managers' reports to the UCG Head Office. The FM reports there have been no complaint investigations by the Health and Disability Commissioner, the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents and their families as part of the admission process. Residents interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held two monthly and review of these minutes provides evidence of residents ability to raise any issues they have, and this was confirmed during interviews of residents.</p> <p>A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of quality/staff meeting minutes and manager's monthly reports evidences reporting of complaints.</p> <p>The ARC requirements are met.</p>

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA

Evidence:

The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Rose Court Lifecare. A 'Rose Court Lifecare Business Plan 2013 - 2014', 'Quality Improvement Plan, Ultimate care Group', and 'Risk Management Plan January 2013 - January 2014' reviewed includes a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Also reviewed is documented values, mission statement and philosophy, which are displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

UCG has established systems in place which defines the scope, direction and goals of the organisation and UCG facilities, as well as the monitoring and reporting processes against these systems.

There is an 'Ultimate Care Group Clinical Advisory Group' (CAG) in place that has four clinical services managers (CSMs) and is responsible for reviewing clinical issues and policies and procedures following feedback from each of the 16 UCG sites. Each of the four CSMs is responsible for liaising with four or five UCG sites to ensure their participation in the process. 'Ultimate Care Group Clinical Governance Group Terms of Reference' are reviewed.

Meeting schedules and minutes reviewed show that monthly quality/staff and registered nurse (RN) meetings are held, as are two monthly resident meetings. Meeting minutes are available for review by staff along with clinical indicator reports, graphs, and benchmarking data.

The facility manager (FM) and clinical services manager (CSM) provide weekly and monthly reports to the governing body and these are reviewed. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators.

Rose Court Lifecare has a facility manager (FM) and a clinical services manager (CSM). The FM is a registered nurse with extensive aged care experience. The FM has spent the last 43 years working in aged care, the last 10 years in management and the six years prior this in a clinical management role. The FM was appointed to this position in July 2012. The FM is supported by a CSM / registered nurse (RN) who is responsible for oversight of clinical care provided to residents. The CSM has been in this position since November 2011. The CSM has spent the last seven years in clinical management positions, and was working in another Ultimate Care Group facility in the same role for two and a half years prior to their transfer to Rose Court Lifecare. Review of the managers' personal files and interview of the FM and CSM indicates the managers undertake training in relevant areas. Twenty four hour RN cover is provided. Support for the FM and CSM is provided by a Regional Operations Managers for UCG.

Rose Court Lifecare is certified to provide hospital level care and rest home level care and there are 75 beds provided. All except five beds are able to be used for either rest home or hospital use. On day one of this audit there are 19 hospital residents and 40 rest home residents.

Ultimate Care Group Limited have contracts with the DHB to provide aged related residential care (rest home and hospital services), and day care and respite care.

The ARC requirements are met.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Attainment and Risk: FA
Evidence: Criteria 1.2.3.6 and 1.2.3.8 were partially attained during the last audit and are now fully attained.

The Ultimate Care Group (UCG) 'Quality and Risk Management Plan - 2012 - 2014' is used to guide the quality programme and includes quality goals and objectives. The Ultimate Care Group (UCG) quality and risk management systems are imbedded at Rose Court Lifecare. Rose Court Lifecare has an established, documented, and maintained quality and risk management system.

UCG launched 'Releasing Time to Care' (RTTC) modules at some trial sites in January 2012 and rolled it out to all UCG sites in August 2012. Rose Court Lifecare has integrated elements of the RTTC modules in to their service.

There is an internal audit programme in place and completed internal audits for 2013 are reviewed. Review of quality improvement data provides evidence the data is being reported to Ultimate Care Group Head Office via their intranet as well as to staff via various meetings. Combined quality improvement / staff meetings are held monthly and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Registered nurse (RN) meetings are also held monthly and resident meetings are held two monthly.

UCG implemented an electronic database (Inscribe database) in December 2012 which is used to input clinical indicators on a daily basis. This information is available for review by staff at UCG head office. Information on this database, including benchmarking graphs, is reviewed. Clinical indicators are recorded on various registers and forms and are reviewed during this audit. There is documented evidence of collection, collation, and reporting of quality improvement data including reporting on numbers of various clinical indicators, quality and risk issues, and discussion of any trends identified in the monthly quality/staff meetings and RN meetings.

Internal audits, accident/incident forms, and meeting minutes reviewed provide evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed to address the issue/s that require/s improvement. There is documented evidence available indicating that issues identified as requiring follow through at meetings are discussed at subsequent meetings (eg, quality/staff, RN and residents meetings).

Staff interviewed report they are kept informed of quality and risk management issues including clinical indicators. Copies of meeting minutes are available for staff to review in the staff office.

Resident and family satisfaction surveys were completed in October 2013 and collated results reviewed and indicate the majority of responders are either satisfied or very satisfied with the various aspects of service provided.

The FM and CSM are responsible for providing 'Weekly and Monthly Report' to UCG Head Office and these provide evidence of reporting of clinical indicators and quality improvements - including education and internal audits. Other areas reported on include occupancy, staffing and HR, Resident 'Ins and Outs', Property/Environmental Issues, Financial, General Comments, Compliance/Indicator Summary.

Quarterly internal audits are being undertaken by the manager audit and compliance from the Ultimate Care Group to ensure compliance with the quality and risk management programme, certification requirements, and funding contract requirements. Corrective action plans are developed following these internal audits to address any improvements required and the facility is re-audited if required to achieve compliance with the standards set by the organisation. The outcomes of these audits are reported to the Board.

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed that are relevant to the scope and complexity of the service reflects current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. The CAG from UCG is responsible for reviewing policies and procedures. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via handover and meetings.

Health & Safety Manual available that includes relevant policies and procedures. Risks are identified, and there is a hazard register that identifies health & safety risks as

well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. Chemical Safety data sheets available identifying potential risks for each area of service. Planned maintenance and calibration programmes in place and reviewed and all biomedical equipment has appropriate performance verified stickers in place.

The requirements of the ARC are met.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: FA
Evidence: <p>The adverse event reporting system provides evidence of a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG Inscribe electronic database, and filed in resident files. 2013 data reviewed includes summaries and registers of various clinical indicators including falls, medication errors, unintentional weight loss, skin tears, and behaviour. Documentation reviewed and interviews of staff indicates appropriate management of adverse events.</p> <p>An 'Incident Management Form' is used to document all incidents that are referred to UCG head office.</p> <p>There is an open disclosure policy. Resident files reviewed (two hospital and three rest home) provide evidence of communication with families following adverse events involving the resident, or any change in the residents condition.</p> <p>Staff confirm during interview that they are made aware of their essential notification responsibilities through: job descriptions; policies and procedures; and professional codes of conduct, which was confirmed via review of staff files and other documentation. Policy and Procedures comply with essential notification reporting (eg, health and safety, human resources, infection control).</p>

ARC requirements are met.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: PA Low

Evidence:

Written policies and procedures in relation to human resources management are available and are reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (eight of eight) along with reference checking, criminal record vetting, interview questionnaires, employment agreements, completed orientations and competency assessments (with exceptions noted in criterion 1.2.7.5).

The FM and CSM are responsible for management of the inservice education programme and there is evidence available indicating inservice education is provided for staff at least once a month. Staff are also rostered off the floor to attend one of the two eight hour compulsory study days provided each year. The FM advises that as well as the compulsory study day that is being provided, in 2014 they will also provide an additional four hour study day.

Individual records of education are maintained for each staff member and copies are reviewed on staff files. Also viewed competency assessment and education spread sheets as well as education records for each session and inservice education programmes. Not all staff have completed all of the competency assessments they are required to complete and improvements are required (see criterion 1.2.7.5).

Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the Aged Care Education (ACE) modules. All caregivers are required to complete the ACE modules. It is UCG policy that all RNs are required to complete the ACE Dementia education modules.

An appraisal schedule is in place and current staff appraisals sighted on all staff files reviewed. Annual practising certificates are current for all staff who require them to practice.

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff advise they are 'buddied' for at least three days at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided (ie, the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation's vision, values & philosophy).

Care staff interviewed (two caregivers working morning shifts, two caregivers working afternoon shifts and two RNs working all three shifts) confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.

Not all of the ARC requirements are met.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:**Timeframe (days):** (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: PA Moderate**Evidence:**

Spreadsheets are reviewed with completion dates and due dates for completion of various competency assessments. There are 22 staff members names on the list who require completion of medication competency assessments. Of the 14 caregivers, one of these is overdue for their next competency assessment; one EN has a current competency assessment as required; of the six RNs, one does not have a current competency assessment and was completing their competency assessment on the day of this audit; and the CSM who advises they are not directly involved in medicine management, and does not have a current competency assessment.

There are 24 names on the register for completion of hand hygiene competency assessments and 18 of these are past their next assessment date. Review of the spreadsheet also indicates not all staff have current hoist/manual handling competency assessments.

Programmes for the two staff education days provided in July 2013 and October 2013 are reviewed along with attendance records and individual training records.

Spreadsheets are also reviewed for performance appraisals and these are current. This is also confirmed during review of staff files and interviews with staff.

Finding:

Competency assessments are not current for all staff involved in medicine management. Not all staff have completed current hand hygiene and manual handling competency assessments.

Corrective Action:

Provide documented evidence that all staff have completed the appropriate competency assessments and that these are completed on a regular basis.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)**Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)**

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA**Evidence:**

There is a clearly documented rationale ('Policy For Service Management') for determining service provider levels and skill mixes in order to provide safe service delivery in place at Rose Court Lifecare. The staffing rationale is based on 'SNZ:HB 8163:2005 Indicators for Safe Aged-care and Dementia-care for Consumers' - 'Table 4

Recommended hours per consumer'. 'The Ultimate Care Group Rostering Tool' is used by the facility manager to report to UCG head office on a weekly basis. Registered nurse cover is provided 24 hours a day. The minimum amount of staff is provided during the night shift and consists of one registered nurse and two caregivers. The facility manager, clinical services manager and a senior registered nurse have a roster for who is on call after hours.

Caregivers interviewed report that there is enough staff on duty and they are able to get through the work allocated to them. Residents interviewed report there is enough staff on duty to provide them with adequate care.

ARC requirements are met.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Attainment and Risk: FA
Evidence: An area requiring improvement from the last audit is now fully attained. Residents' files reviewed, (five of five) provides evidence that staff record their name and designation and sign each entry. ARC requirement D7.1 is met.

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.3: Continuum of Service Delivery

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.

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c.i; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: FA
Evidence: <p>The area requiring improvement identified at the last audit is now fully attained. Four of five residents' files reviewed have evidence that the resident was seen by the GP within the stated timeframe. One of the five residents was seen six days following admission, however there is evidence of communication with the GP on the day of the resident's admission and again two days later requesting a visit from the GP.</p> <p>Five of the five residents' files reviewed (two hospital and three rest home) including two resident's files, provide evidence that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been developed with resident or family input and the service is co-ordinated to promote continuity of service delivery. Six of six clinical staff interviews (two RNs and four care givers) confirm residents or family members are involved in all stages of service provision. Residents confirm their input into the development of their care plans. Four residents' files reviewed demonstrate that care plans are developed by the RNs. The care plan for the rest home resident is developed by an enrolled nurse (EN) and countersigned by an RN. Care plans have good detail and guide staff. Care plans are signed off by the resident or family member, meet appropriate timeframes and demonstrate team approach into reviews and evaluations. Risk assessments are completed on admission and at least three monthly and include Norton scale for pressure areas, Coombes assessment, pain, oral mental score test, and nutritional assessment. Family communication records are maintained, sighted in all five residents' files. There is a process to identify and respond to variances/trends (e.g. accident / incident / unwanted events reporting system). An 'Incident Notification to Families' form documents the timeframes when family wish to be notified according to whether Incidents/Accidents are falls without injury, minor injury or minor skin tears. Documentation reviewed provides good evidence that skin integrity monitoring, the</p>

management of wounds, and falls with injury are managed well. Multidisciplinary reviews of care are completed annually. GP notes reviewed show three monthly reviews and all residents have a GP exemption for monthly reviews signed by the GP.

Handover between the morning and afternoon shifts was observed where the morning shift RN handover to the afternoon shift care staff. The handovers are both written and verbal, and RNs carry out a physical round of residents. The GP who has the majority of residents is interviewed on site and reports the care provided to residents is very good, and that the RNs are knowledgeable.

Competency assessments are not current for all staff that are responsible for the management of medicines. (See criterion 1.2.7.5 and link to 1.3.12.3). All staff in contact with residents have received on-going education in challenging behaviour.

ARC requirements are met.

Tracer - Hospital

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer – Rest Home

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Attainment and Risk: FA
Evidence: The area requiring improvement from the last audit is now fully attained. Ratings from risk assessments are recorded in the all the files reviewed, and the two resident's files who are using enablers have this documented in their care plans.

Residents' needs, outcomes and goals are identified via the assessment process and are recorded in a timely manner as confirmed for all residents files reviewed. There are processes in place to seek information from a range of sources, for example, family, GP, specialists and referrer. Policies and protocols are in place to ensure co-operation between service providers and to promote continuity of service delivery. Residents' files reviewed provides evidence residents' discharge/transfer information from DHB or other health provider is available and appropriate resources and equipment are available. Care staff interviewed confirms that assessments are conducted in a safe and appropriate setting including visits from the GP. All residents interviewed confirm their involvement in their assessments, care planning, review, treatment and evaluations of care. Five of five residents' files evidence risk assessments on admission are conducted and recorded, and risk assessments are completed at least three monthly, in line with the care plans. These include Norton scale for pressure areas, Coombes assessment, pain, oral mental score test, and a nutritional assessment.

ARC requirement is met.

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Attainment and Risk: FA
Evidence: Documentation and observations made of the provision of services and interventions demonstrate that consultation and liaison is occurring with other services, this includes a range of nurse specialists from the DHB. Five of five residents' files reviewed provide evidence care plans record appropriate interventions provide good detail and are based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident completing an intervention themselves is recorded in the care plans. GPs documentation and records are current. Visual inspection evidences adequate continence and dressing supplies in accordance with requirements of the service agreement. Residents interviewed confirm their current care and treatments meet their needs. Family/Whanau communication sheets and progress notes record family communications, as sighted in all five residents' files reviewed.

ARC requirements are met.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Attainment and Risk: FA
Evidence: <p>There is an activities programme for the two resident groups residing in Rose Court that supports their interests, needs and strengths. A copy of the programme is given to all residents. Two activity officers job share and provide activities in groups, and one to one for residents who are unable to attend the group activities. Residents interviewed confirm they enjoy the activities provided. They report they can choose what they would like to participate in. Five of five resident files reviewed have completed resident profiles and activity care plans. The activity officers are interviewed and report the van outings are very popular, and this is sighted on the planned activity programme.</p> <p>ARC requirements are met.</p>

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA
Evidence: <p>Five of five residents' files reviewed provide evidence that evaluations of care plans are within stated timeframes, at least three monthly. Evaluations are conducted by the RNs with input from the resident, family, care staff, and activity officers. Family are notified of any changes in a resident's condition, as evidenced in residents' files reviewed. Resident interviews confirm their participation in care plan evaluations. Input from specialists includes - wound specialist nurse, speech language specialist, infection control specialist, and dietitian. Residents' files evidence referral letters to specialists and other health professionals. Short term care plans are in place on residents' files for short term changes in condition, and care plans are updated to reflect changes.</p> <p>ARC requirements are met.</p>

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Attainment and Risk: FA
Evidence: <p>An area requiring improvement from the last audit is now addressed. There are no residents who self-administer their own medicines and it has been policy since August 2012 that Rose Court does not facilitate self-administering of medicines. Medicines are dispensed and delivered by the pharmacy using the Medico system. Each medicine prescribed is signed by the GP. Each resident has an individual medicines profile and medicine prescription form, and medicine signing sheets. The GPs complete a medicine reconciliation on admission for residents. A controlled drug register is maintained and evidences weekly and six monthly checks. Bulk medicines are held for a small amount of controlled drugs and other medicines. Medicines requiring refrigeration are stored in a dedicated fridge, in the medication room. The temperatures are recorded on a weekly basis and are within the recommended range for medicines.</p> <p>Medicine reviews by the GPs are recorded in the medicine charts at least three monthly as confirmed in 10 of 10 medicine files reviewed. There is evidence staff are signing off as the dose is administered. This is observed during a medication round.</p>

RNs, EN and senior caregivers are responsible for medicine management, and have received education, however not all care staff have current competencies (see criterion 1.2.7.5). The medication round was observed at lunch time where medicines were observed to be managed safely. The GP reports the management of medicines is managed very well, and the GP has no concerns.

A medication audit was completed on 25 November 2013 and a pharmacy audit was conducted on the 19 November 2013. The pharmacist interviewed on site and reports medicines are managed very well and the staff work closely with the pharmacist. Medicine management complies with current legislative requirements and safe practice guidelines.

ARC requirements are met.

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: PA Low
Evidence: Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Menus are four weekly, and are planned and

reviewed in May 2013.

A satisfaction survey completed in October 2013, review of resident meeting minutes and interviews of residents indicates that the meal service is adequate. Residents interviewed report they enjoy the meals and the lunch time meal is observed during this audit. Residents also confirm that adequate fluids are provided and snacks are available between meals (e.g. fruit, bread, sandwich fillings, biscuits, cake, and supplements).

Residents' files reviewed (two hospital and three rest home), demonstrate regular monthly weighing and monitoring of individual's resident's weight and nutritional needs. Dietary profile sheets are completed on admission and copies of these are held in a folder in the kitchen and are reviewed during this audit. Residents care plans identify nutritional needs and interventions are documented. Residents are referred to the dietitian with input from their GP, if they experience unintentional weight loss. Referrals are also made to a speech language therapist if required.

Visual inspection of the kitchen and food areas evidences the areas are maintained and cleaned to an adequate standard although improvements are required to some areas (see criterion 1.3.13.5).

Interview with the cook confirms kitchen staff have received education on food safety and chemical safety. Emergency food and water supply is stored at the facility. Interview of the cook confirms the cook has knowledge of individual resident's likes and dislikes and special diets. Kitchen and food handling audits are completed on a regular basis.

Not all of the ARC requirements are met.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: PA Low
<p>Evidence:</p> <p>Fridge and freezer and food temperatures are monitored daily in the kitchen but fridge temperatures are not being monitored in the fridges in the hospital and apartment kitchenettes.</p> <p>There is a large crack in vinyl floor covering in the kitchen and the walls also have cracks. The FM advises this is earthquake damage and that they are waiting for an engineer's report before EQC will pay for repairs. Visual inspection indicates that the vinyl flooring has duct tape across it to assist with maintenance of hygiene standards but this duct tape has lifted at the edges and has blackened over time. Cracks are also evident in the vinyl where it is covered up under the cupboards. A weekly undated cleaning schedule is sighted.</p> <p>Visual inspection of the pantry and storage areas for dry goods indicates there is not a lot of storage space. Dry goods are not being dated when they are decanted in to other containers. The kitchen is compact. Kitchen staff are not documenting dates on the cleaning schedule to indicate the date the cleaning has been completed</p>
<p>Finding:</p> <p>(i) Vinyl flooring has a large crack through the middle and where the vinyl is covered up under the cupboards. (ii) Dry goods are not being dated when they are decanted in to other containers. (iii) Kitchen staff are not documenting dates on the cleaning schedule to indicate the date the cleaning has been completed. (iv) There is no documented evidence available to indicate that fridge temperatures are being monitored in the fridges in the hospital and apartment kitchenettes.</p>
<p>Corrective Action:</p> <p>Provide confirmation that: (i) the vinyl flooring has been replaced/repared; (ii) the date the dry goods are decanted is being recorded on the containers these dry goods are decanted in to; (iii) kitchen staff are recording the date the cleaning is completed; and (iv) fridge temperatures are being monitored and documented in the fridges in the hospital and apartment kitchenettes.</p>
Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Attainment and Risk: FA
Evidence: Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 1 April 2014. ARC requirements are met.

Evidence:

Service provider's documentation and visual inspection evidences current Building Warrant of Fitness that expires 1 April 2014.

ARC requirements are met.

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: There are currently no residents using restraint and two residents using an enabler. Documentation of restraint minimisation and safe practice policies and procedures, and their implementation, demonstrate residents are experiencing services that are the least restrictive. The CSM reports they have introduced ultra-low beds and sensor mats and monitor residents more often so that restraint is not used.

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA

Evidence:

Review of documentation provides evidence the surveillance reporting process in place is applicable to the size and complexity of the organisation. All infections are recorded on 'Infection Control Summaries Form' and on individual resident infection register. Residents with infections have a short term care plan to address the infection. Reviewed on resident's files

Results of surveillance are reported on the UCG electronic database. Collated reports with analysis of this infection surveillance data are reviewed. Clinical indicators are reported monthly to the combined quality/infection control/staff/health and safety meetings, to the RN/EN meetings, and via the 'Weekly & Monthly Reports' to the governing body.

Staff interviewed report they are made aware of any infections of individual residents by way of feedback from the RNs and at the daily handovers. They also report this infection surveillance information is made available for them during hand over and at staff meetings. Staff also report copies of meeting minutes are in the staff areas. IC audits are completed as part of the internal audit programme and this was last completed 10 October 2013.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>