# Metlifecare Limited - Palmerston North

## Current Status: 24 February 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

Metlifecare Palmerston North is owned and operated by Metlifecare Limited. On the day of audit 34 beds are occupied consisting of 26 hospital level care residents and eight rest home level residents.

Seven of the nine areas identified as requiring improvement in the previous audit have been addressed two areas remain open. There are three new areas identified for improvement related to corrective action outcome management, staff orientation and assessment processes.

## Audit Summary as at 24 February 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 24 February 2014

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| 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. |

### Organisational Management as at 24 February 2014

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| 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. |

### Continuum of Service Delivery as at 24 February 2014

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

### Safe and Appropriate Environment as at 24 February 2014

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| 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. |

### Restraint Minimisation and Safe Practice as at 24 February 2014

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| 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. |

### Infection Prevention and Control as at 24 February 2014

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

# 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**

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| --- | --- |
| **Legal entity name:** | Metlifecare Limited |
| **Certificate name:** | Metlifecare Palmerston North |

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| **Designated Auditing Agency:** | DAA Group Limited |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance | | | |
| **Premises audited:** | Corner of Grey and Carroll Streets Palmerston North | | | |
| **Services audited:** | Hospital Care (Geriatric Services) and Rest Home Care | | | |
| **Dates of audit:** | **Start date:** | 24 February 2014 | **End date:** | 24 February 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 34 |

## **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 |
| **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**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 12 | Total audit hours | 28 |

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| Number of residents interviewed | 6 | Number of staff interviewed | 10 | Number of managers interviewed | 5 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 32 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed |  |

## **Declaration**

I, XXXXX, 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:

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| --- | --- | --- |
| 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 Thursday, 6 March 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Metlifecare Palmerston North is owned and operated by Metlifecare Limited. On the day of audit 34 beds are occupied consisting of 26 hospital level care residents and eight rest home level residents.   Seven of the nine areas identified as requiring improvement in the previous audit have been addressed two areas remain open. There are three new areas identified for improvement related to corrective action outcome management, staff orientation and assessment processes. |

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| **Outcome 1.1: Consumer Rights** |
| The residents and family/whanau interviewed report that there is a good standard of communication at the service and that information is conveyed in an open and honest manner. Access to interpreter services is documented in the interpreter service policy, which contains contact numbers for interpreter services.   All complaints sighted are recorded appropriately to meet policy requirements. This was an area identified for improvement in the previous audit and is now fully attained. |

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| **Outcome 1.2: Organisational Management** |
| Organisational structures and processes are monitored by Metlifecare head office via an electronic system (Amrisk). The purpose, values, scope, direction and goals of the organisation are clearly documented and regularly reviewed. Documentation identifies key components of service delivery are reported on a quarterly basis at organisational level, and monthly basis at staff meetings.   Service delivery is overseen by the nurse manager (a registered nurse) who has been in the role for seven years. She is supported by the village manager. A signed job description identifies that the nurse manager has the authority, accountability and responsibility for ensuring the provision of services meets residents’ needs.  Corrective action planning is documented, but does not have any identified outcomes, as is required by policy to show effectiveness of actions taken. This requires improvement.  Incidents, accidents and adverse events are recorded, reported, evaluated and benchmarked at organisational level and information is shared with all facility staff. Family/whanau are kept informed and communication related to an event reflects the principles of open disclosure.  Not all information shown on incident and accident forms is followed up to ensure corrective actions are being used as opportunities for improvement. This was an area identified for improvement in the previous audit and is yet to be addressed.   There is an up-to-date risk register which outlines controls that are in place to minimise known and potential risks. The service has an up to date disaster management plan in place which identifies contingency measures to be taken by the site manager at Metlifecare Palmerston North. The service is able to demonstrate that they have been proactive in working with the local civil defence department when undertaking disaster management drills.  The service implements safe staffing levels and skill mixes that are identified as being best practice by the organisation. There is always an identified senior RN on call and/or the nurse manager. Human resources management processes in place meet legislative and policy requirements. All staff appraisals sighted are up to date which addresses a previous required improvement. Staff education is offered regularly throughout the year and attendance is recorded. A newly identified area requiring improvement relates to ensuring all staff orientation records are completed and that all staff files can be accessed.   There is an ongoing area requiring improvement to ensure all progress note entries have the name and designation of the service provider identifiable. This was identified at the previous audit and requires further actions to be fully implemented. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The residents and family/whanau interviewed report overall satisfaction with the service delivery. The service provides appropriate service provision for residents at rest home level of care. Each stage of service provision is undertaken by suitably qualified and experienced nursing and care staff. The assessment, planning, provision and review of care is provided within time frames that meet the residents' needs and complies with contractual requirements. Where there are temporary changes in a resident's condition the service uses an acute care plan to document the changed needs. The previous areas of required improvement related to the continuity of care, pain assessment and the documentation of interventions in the care plan are now addressed and improvements implemented since the last audit. There is a new area of required improvement related to ensuring assessments that identify varying levels of need are responded to with timely referrals to other appropriate health professionals.   The activities programme supports the interests, needs and strengths of the residents. The residents and family/whanau interviewed express satisfaction with the activities provided.   A safe and timely medicine management system is observed at the time of audit. The registered nurses and senior caregivers are responsible for medicine management and evidence competency to perform the role. All staff who manage medicines are assessed as competent to do so. The previous area for improvement to ensure the regular checking of the temperature of the medicine fridge is now addressed  Residents express satisfaction with the food and fluid offered at the service. The menus are appropriate to the resident group and have been reviewed as suitable for residents living in long term aged care services. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility has an up to date building warrant of fitness. One area identified for improvement in the previous audit related to the safe storage of chemicals is now fully attained. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Policy clearly states the use of enablers is voluntary and the least restrictive option to meet the residents’ needs with the intention of maintaining independence and safety. There are three residents with bedside rails which are enablers in use at the time of audit. Enablers are used to allow residents to maintain independence safely. Individual resident’s use of enablers is reviewed at least three monthly. During interview, clinical staff demonstrate in-depth knowledge related to safe enabler and restraint use. |

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| **Outcome 3: Infection Prevention and Control** |
| The results of surveillance of infections are analysed and reported to staff, management and Metlifecare organisational management. Where trends are identified, the service implements actions to reduce the rates of infections. The surveillance results are benchmarked with other Metlifecare aged care services.  At the request of the district health board, further review of the services policy and procedures related to outbreak management were reviewed, as a result of concerns over the management of a recent outbreak of Norovirus at the service. The organisational infection prevention and control policies and procedures comply with relevant legislation and current accepted good practice. The outbreak management records, which includes reporting to the public health department, reflect that the organisational policies and procedures are implemented at the time of the outbreak. The service has conducted reflective activity regarding the outbreak management and have made suggestions of ways to make improvements to the management and communication of the requirements to staff. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 15 | 0 | 5 | 0 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 5 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 30 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 58 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Corrective action plans sighted and follow up actions are documented but no documented evidence of the action outcomes is shown as required in policy. Examples sighted include the follow up from the overall six monthly restraint review which required individual resident’s three monthly restraint reviews to be documented. The nurse manager reports that this action has been completed but no confirming documentation was available to show signoff and/or outcomes. The same issue is found for corrective actions related to the planned annual audit results. | Ensure corrective actions that are implemented are documented to show the outcome, as required in policy. | 180 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | The incident and accident forms sighted have opportunities for improvement identified on some forms but there is no documented evidence that this information is being actively used to improve service delivery. One example relates to a resident who displays challenging behaviour. The incident form identifies that a challenging behaviour log is to be put in place. No log could be found in the resident’s file. | Ensure the information documented on incident and accident forms related to opportunities to improve service is followed up. | 180 |
| 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 |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | On the day of audit not all staff files could be accessed as the village manager is away on annual leave for three weeks and no one else at the facility can access the files for the staff she manages. This includes domestic staff from the laundry, cleaning and kitchen areas.   2. A review of a recently employed RN’s file identifies that none of the orientation criteria has been signed off. | Ensure all orientation processes are undertaken and signed off when completed and that staff files are accessible to management at all times. | 180 |
| HDS(C)S.2008 | Standard 1.2.9: Consumer Information Management Systems | Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.9.9 | All records are legible and the name and designation of the service provider is identifiable. | PA Low | Not all progress note entries in the five of five residents’ files have entries that record the staff member’s name, signature and designation. | Ensure all progress note entries have the name and designation of the service provider identifiable. | 180 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Assessment identifies varying needs levels with no documented corresponding referrals sighted. | Ensure the needs of the residents identified through the assessment process are responded to within appropriate timeframes to ensure the correct level of service delivery is offered. | 180 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Family/whānau communication is clearly documented in the five of five resident file reviews and on incident and accident forms sighted. The six of six residents and two of two family/whanau report they receive full and frank information from staff.   Wherever necessary and reasonably practicable, interpreter services are provided. Contact details for the interpreter service are clearly set out in resident admission information and in policy. There are no residents who require interpreter services at the time of audit.   ARRC 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service ensures that residents, family/whānau and visitors have easy access to complaints forms which are available at the entrance to the facility. The nurse manager confirms that the complaints process is discussed as part of the admission process. Interviews with six of six residents (three hospital and three rest home) residents and two of two family/whānau members confirm they understand the complaints process.  There is an up to date complaints register which shows the date the complaint was received, the actions taken and the outcome. All complaints are reported and recorded at organisational level via a computer system (Amrisk) and monitored for effective outcomes. This was an area identified for improvement in the previous audit and is now fully attained.   At the time of audit there are two outstanding internal complaints and documentation identifies letters of acknowledgement have been sent to the complainant within required timeframes and meetings have been undertaken. This process is being managed with support from staff from Metlifecare head office.   Corrective action planning is identified as required, such as staff education and closer monitoring of response to the call bells.   Two to two registered nurses (RNs) and five of five caregivers confirm they implement the complaints process to meet policy requirements.  ARRC requirements are met. |

##### **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.

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

##### **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.

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

## **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisation’s purpose, values, scope, direction and goals are identified in the 2013/2014 Business Plan sighted. This plan is graduated down to show Metlifecare Palmerston North specific goals which are reported against quarterly to the Metlifecare head office. Actions taken to achieve goals are clearly shown.   The nurse manager is a RN who has a current practising certificate. She has worked at the facility for ten years, seven years as the nurse manager and three years as a clinical RN. Her authority, accountability and responsibility for the provision of clinical care service are identified in the job description. The nurse manager stated she maintains her educational level to allow effective management and up to date clinical skills which includes attendance at Metlifecare annual conference and attendance at onsite and offsite ongoing clinical education. The nurse manager is a certified Health Ed assessor. She is supported by the village manager who has the overall responsibility for all service delivery across the facility.   Interviews with two of two family/whānau members and six of six residents (three hospital and three rest home) confirm they are very happy with the services provided and that their needs are met.  ARRC 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Organisational quality and risk management systems are implemented at Metlifecare Palmerston North as confirmed in documentation sighted and during interview with the nurse manager and clinical support manager (who represented Metlifecare head office). Key components of service delivery are explicitly linked to Metlifecare quality and risk systems. One example relates to follow up from a recent complaint that reported there was lack of family involvement in care planning. The service now has a documented system in place to identify family involvement in care planning and this is reported on quarterly to head office.   Monthly staff meetings have a set agenda which identifies that all key components of service delivery are discussed. Staff interviews (one cook, one diversional therapist, two RNs, five caregivers, one housekeeping supervisor and one cleaner) confirm they are informed of any corrective actions that are required. Corrective actions are documented but not all policy requirements are met as outcomes from corrective actions are not documented and this is an area identified as requiring improvement.  Staff interviews confirm awareness of policies and procedures and that they are advised of any new policies or updates at staff meetings and/or on the staff notice board. Policies are managed at organisational level and updates are sent electronically to each facility as required. All policies and procedures sighted at Metlifecare Palmerston North are current, aligned with good practice and meet legislative requirements. The service has a document control system in place. Policies are available to all staff in hard copy and RNs can access them via computer.   Actual and potential risks are identified, documented, and where appropriate, communicated to residents, family/whānau and visitors. All risks are identified in the hazard register which was updated in November 2013. New risks are discussed at staff, resident and family/whānau meetings as appropriate. This is confirmed in staff meeting minutes sighted and in documentation sent out to family/whānau members and residents related to a recent outbreak of Noro-virus.   Owing to the recent spate of earthquakes in the region the DHB asked for risk management around emergencies and external environmental disasters to be looked at in depth to cover ARRC D19.3 (a)I and (a) v. Findings: The organisation’s Disaster Management Policy was updated in July 2013. The Disaster plan sighted identifies functions and responsibilities of emergency support personnel with a list of community disaster management contact numbers such as a plumber, locksmith, fire service and gas supply. This information is kept in the care facility and in the village manager office. Incident management around disasters was one topic of focus at the Metlifecare operations conference in February 2014 which the nurse manager and village manager attended. This included discussion around the updated disaster management plan and a detailed presentation related to the learning’s that occurred following the Christchurch earthquake in 2011. Metlifecare Palmerston North undertook an evacuation drill with the local civil defence in February 2013 and 20 staff were involved.   ARRC requirements 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.

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

##### **Criterion 1.2.3.3 (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.

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

##### **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.

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

##### **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.

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

##### **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.

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

##### **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.

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

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Quality improvements are identified and actions are written but it cannot be verified that corrective actions have been fully implemented as outcomes are not shown or monitored as required to meet policy requirements. |
| **Finding:** |
| Corrective action plans sighted and follow up actions are documented but no documented evidence of the action outcomes is shown as required in policy. Examples sighted include the follow up from the overall six monthly restraint review which required individual resident’s three monthly restraint reviews to be documented. The nurse manager reports that this action has been completed but no confirming documentation was available to show signoff and/or outcomes. The same issue is found for corrective actions related to the planned annual audit results. |
| **Corrective Action:** |
| Ensure corrective actions that are implemented are documented to show the outcome, as required in policy. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The nurse manager and two RNs confirm their knowledge and understanding of essential notification reporting requirements as identified in policy to reflect legislative requirements. As requested by the Ministry of Health, completed documentation was sighted related to an ACC investigation undertaken in November 2012. Corrective actions include ongoing staff education around medication competencies and knowledge of pharmaceutical requirements. Any medication errors now require the nurse involved to undertake a reflective writing process which is reviewed with the nurse manager. All correct notifications have been made related to a recent Noro-virus outbreak at the facility.   Adverse events are documented on incident and accident forms and it is clearly shown that family/whānau are informed as appropriate to reflect the principles of open disclosure. Interviews with two of two family/whānau members confirm they are kept fully informed of concerns staff may have or if any issues arise.  Incident and accident data is discussed at monthly staff and management meetings. Information is recorded electronically via Amrisk and head office undertakes trending, benchmarking and monitoring activities with collated data. This information is used as an opportunity to improve service delivery via corrective action planning.  The service identifies strategies put in place in response to incidents and accidents on the incident forms. However, one incident form sighted identifies that a resident with dementia requires a challenging behaviour log to be kept. This could not be found in the resident’s file on the day of audit. This was an area identified for improvement in the previous audit and remains open.   ARRC 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.

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

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service documents adverse, unplanned or untoward events on incident and accident forms. All the forms sighted identify opportunities to improve service delivery as appropriate but are not always followed up as is required to meet policy requirements. This is an area identified for improvement in the previous audit and remains open. |
| **Finding:** |
| The incident and accident forms sighted have opportunities for improvement identified on some forms but there is no documented evidence that this information is being actively used to improve service delivery. One example relates to a resident who displays challenging behaviour. The incident form identifies that a challenging behaviour log is to be put in place. No log could be found in the resident’s file. |
| **Corrective Action:** |
| Ensure the information documented on incident and accident forms related to opportunities to improve service is followed up. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Human resources management policies and practices are overseen at organisational level. They ensure all professional qualifications are validated prior to staff commencing work, for staff that require them. Processes in place help the organisation to appoint appropriately skilled and knowledgeable staff so that residents’ needs are met. Up to date annual practising certificates are sighted for all staff that require them including RNs, pharmacists and 16 GPs. Eleven staff hold current first aid certificates.   Interviews with six of six residents (three hospital and three rest home) and two of two family/whānau members confirm staff deliver services in a professional manner that meets all their needs.   A review of one diversional therapist, two caregivers and two RNs (one being the nurse manager) files identifies that all good employer human resources procedures occur. All files have job descriptions, signed contracts and education documented. There is an annual education calendar which identifies planned onsite and off-site education that is related to the service provided.   The service has put an electronic system in place to alert the nurse manager when staff appraisals are due. This was an area identified for improvement in the previous audit and is now fully attained.   The orientation process is set at organisational level includes health and safety, infection control, activities, management and administration and policies and procedures. One file review undertaken for an RN who commenced work within the last 12 months does not have any signed orientation documentation and access could not be gained to files for staff who work in the kitchen, laundry or cleaning areas. These are new areas identified as requiring improvement.  Interviews with ten of ten staff confirm the orientation and induction processes offered allows them to undertake the role they are employed to do.   ARRC 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.

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

##### **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.

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

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service has a documented comprehensive orientation programme in place for all job roles. Corrective actions are completed related to ensuring alerts are entered onto the electronic system to show when all staff appraisals are due. All staff appraisals sighted are up to date. One caregiver file reviewed did not have a three monthly post-employment appraisal completed but the new electronic alert system has only been in use over the past three months and this staff member has been working for one year. This was an area identified for improvement in the previous audit which is now fully attained. However, there is a new area identified for improvement related to completion of a staff member’s appraisal and lack of access to all staff files. |
| **Finding:** |
| 1. On the day of audit not all staff files could be accessed as the village manager is away on annual leave for three weeks and no one else at the facility can access the files for the staff she manages. This includes domestic staff from the laundry, cleaning and kitchen areas.   2. A review of a recently employed RN’s file identifies that none of the orientation criteria has been signed off. |
| **Corrective Action:** |
| Ensure all orientation processes are undertaken and signed off when completed and that staff files are accessible to management at all times. |
| **Timeframe (days):** 180 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Metlifecare have a process in place which determines safe staffing levels. Rosters sighted identify the process is implemented at Metlifecare Palmerston North. Staff replacements for sickness and annual leave are clearly shown on four weeks of rosters sighted. All shifts are covered by a RN who holds a current first aid certificate. This is monitored at organisational level as well as facility level and safe staffing numbers are shown on the rosters sighted.   Staff interviews across a range of services, including clinical, housekeeping, kitchen and activities, confirm that staffing levels and skill mix allows all residents' needs to be met in a timely manner and that they have time to complete all tasks each duty. Resident and family/whānau interviews report all their needs are met in a timely manner.   The MidCentral District Health Board queried availability of staff on site to make appropriate decisions following an incident which occurred during a recent infection control outbreak. This was discussed with the nurse manager and via telephone with the village manager who is on annual leave the day of audit. They felt full explanations had been given to the person from the DHB who made enquires.  The service has policies and procedures related to senior staff availability including the nurse manager and a senior RN being on call. All roster sighted clearly identify who is on call after hours and during the weekend. Interviews with seven of seven clinical staff confirm they understand and are aware of who to contact after hours. A comprehensive list of staff cell phone numbers is sighted on the wall in the nurses’ office for any staff member to use. The nurse manager and clinical support manager representing Metlifecare head office confirm that for clinical expertise the director of nursing for Metlifecare is always available via telephone along with the quality and risk manager.   ARRC 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.

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

#### 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The previous corrective action request at 1.2.9.9 identified that staff do not write their full name or designation when making an entry into the residents' notes. The recommended action is to ensure all entries in residents' notes are legible and that the name and designation of the service provider is identifiable. This still remains a corrective action. Refer to CAR at 1.2.9.9 |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Not all progress note entries in the five of five residents’ files have entries that record the staff member’s name, signature and designation. Some entries did have the staff member’s signature, printed name and designation. Other entries have the staff member’s signature and designations and other entries have the staff member’s initials and designation. A corrective action is required to ensure all progress note entries record the name and designation of the staff member. |
| **Finding:** |
| Not all progress note entries in the five of five residents’ files have entries that record the staff member’s name, signature and designation. |
| **Corrective Action:** |
| Ensure all progress note entries have the name and designation of the service provider identifiable. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **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; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There was a previous corrective action at 1.3.3.4 with the findings that no specific registered nurse is responsible for monitoring continuity of residents' care. A resident's weight loss has gone undetected. The corrective action required that services are coordinated to promote continuity of care. This is now addressed and an area of improvement implemented since the previous audit.   Each stage of service delivery is undertaken by suitably skilled staff. The RN conducts the nursing assessment, develops the care plan (with consultation with the caregivers, resident and family), and evaluates and reviews the care. GP review occurs at time frames that meet the resident's assessed needs, at least three monthly where assessed as stable (confirmed in the five of five residents' files reviewed). The five residents’ files reviewed include three hospital level of care residents and two rest home level of care (one being a rest home level of care resident living in the apartments). The time frames for the minimum medical reviews are recorded on the GP consultation page in the five of five residents' files reviewed (three hospital and two rest home level of care).   The caregivers provide the majority of the personal care for the residents. The annual practising certificates (APCs) are sighted for all staff who require them. The six of six residents (three rest home and three hospital) and two of the two family interviewed expressed an overall satisfaction with the care provided. One family member did state that even though overall satisfaction with the care of their relative and most staff are ‘fantastic’, they felt that the occasional staff were ‘uncaring’ in the way they treated their relative. This relative did wish to remain anonymous and was offered an opportunity to express their concerns directly and confidentially with the Metlifecare management, but declined this offer.   The lifestyle care plan covers hygiene, rest and sleep, skin integrity, nutrition, restraint (if required), elimination, communication, memory, cognition and behaviour, pain management, vision, hearing, culture, spiritual, sexuality, psycho-social needs, death and dying, family and significant other input into care. The lifestyle plan records the risk factors (eg, falls, skin integrity, weight loss and challenging behaviours). The initial assessment and initial care plan are conducted on the day of admission (confirmed in five of five residents' files) and the long term care plan is developed within three weeks of admission (confirmed in five of five residents' files reviewed). The assessments are reviewed at three monthly intervals (confirmed in five of five residents' files), with a summary of these provided on the evaluation form. The evaluation of care is conducted at least six monthly, the five of five residents’ files reviewed evidencing three monthly review of assessments and care evaluation.   The six clinical staff (one RN and five caregivers) report that a verbal handover is provided each shift. The clinical staff report that the care is co-ordinated to provide continuity of care and that they are informed of any changes to the residents or their care needs. RNs are allocated a number of residents as their primary nurse/case manager and are responsible for the review, assessments, care planning and evaluation of care for these residents.   Tracer example one - hospital level of care:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer example two – rest home level of care  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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The previous CAR at 1.3.4.2 identified that residents on regular pain relief have no pain assessment documented, as requested and appropriate, in their care plans. The five of five residents’ files reviewed (three hospital and two rest home) have pain assessments. The interventions for pain management are identified in the care plans for the five of five residents’ files reviewed. This is now addressed and an area of improvement implemented since the last audit. A new corrective action request is made at 1.3.4.2 to ensure the needs of the residents identified through the assessment process are responded to within appropriate timeframes to ensure the correct level of service delivery is offered.  The service has a continence assessment and management procedure, wound care management procedures, wound care protocols and behaviour management processes, which include seeking expert assistance, such as, mental health services, as required. Where a need is identified, interventions for this are recorded on the care plan. The files of five of five residents reviewed have pain identified as a need and these residents' files evidence a pain assessment, which includes the use of a pain scale. All of the five files reviewed have falls risk assessments. Where there is a moderate to high falls risk, additional falls and balance assessments are conducted and specific plans developed to reduce falls. The rest home resident reviewed has additional assessments for wound care. The hospital level of care resident reviewed has specific assessments and interventions for their chronic medical condition.   The six of six residents and two of two family interviewed report they are overall satisfied with the care provided. Also refer to 1.3.3.3 for the comments of one family member, where they felt overall satisfaction with care provided most of the time but did raise some concerns.    The ARRC requirements for rest home level of care are 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The file reviewed of the rest home resident living in the apartment area of the retirement village has care needs in the care plan that reflect hospital level of care. The assessed needs of the resident are identified and provide a basis for care delivery. The resident is assessed as rest home level of care, though the needs recorded in the care plan reflect a greater level of care is required for the resident. The resident was assessed for rest home level of care in October 2011. The care plan records the increasing dependencies of the resident since the care plan review and evaluation in May 2014. The care plan records that the resident now requires full assistance with showering, dressing, eating and repositioning. The resident requires two persons and hoist for transfers and requires a wheelchair for all mobility. The care plan records the resident is verbally and physically aggressive and requires the use of bed rails as restraint. The six of six care staff interviewed (five caregivers and one RN) felt that the resident has a high level of needs. The resident has not been referred for re-assessment at the time of audit. The staff report that they are able to provide the increased needs for the resident. The apartment, which is on the same level of the care facility, is not approved to provide hospital level of care.   Through review of the incident forms (refer to 1.2.4.3) a resident with mental health issues has not been referred to assessment by the mental health service and a resident with challenging behaviours has not had a challenging behaviour log commenced. |
| **Finding:** |
| Assessment identifies varying needs levels with no documented corresponding referrals sighted. |
| **Corrective Action:** |
| Ensure the needs of the residents identified through the assessment process are responded to within appropriate timeframes to ensure the correct level of service delivery is offered. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous corrective action request at 1.3.6.1 identified that regular pain relief is being given, however, no pain assessment is undertaken. For one resident there is no sighted analysis on recorded episodes of challenging behaviour, or detailed interventions to manage the behaviour. A short term care plan is not used when a resident has a urine infection. The corrective actions required that provision of service and / or interventions are consistent with, and contribute to, meeting residents' assessed needs, and desired outcomes. This is now addressed and an area of improvement implemented since the last audit.  The five of five residents’ files reviewed (three hospital and two rest home) have pain assessments. Two of the five residents reviewed are assessed as having challenging behaviours, with the care plan identifying the triggers, de-escalation techniques and interventions to manage challenging behaviours (a supplementary file reviewed at 1.2.4.3 did not have a challenging behaviour log, refer to CAR at 1.2.4.3 and 1.3.4.2). The five of five files reviewed have short term care plan for infections.   The five of five care plans reviewed record interventions that are consistent with the residents' assessed needs and desired goals. The file of the hospital resident reviewed as specific interventions related to the chronic medical condition. The file of the rest home resident reviewed has specific interventions for wound care. The five of five caregivers interviewed report that the care plans are accurate and up to date to reflect the resident’s needs. The six of six residents and two of two family/whānau interviewed report that the service meets the needs of the resident.  The ARRC requirements for rest home level of care 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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The five of five residents' files reviewed have activities and social assessments. Daily activities attendance sheets are maintained and reviewed at the end of each month to assess the enjoyment and interests of the residents. The goals are updated and evaluated in each resident's file six monthly. A weekly activities plan (sighted) is developed based on the resident’s needs, interests, skill and strengths. The activities cover cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities. Residents are also observed at the time of audit to be engaging in independent activities, such as going out into the community, reading, listening to music and doing exercises.   The diversional therapist (DT) reports that they gauge responses and review the attendance records in assessing if the residents are interested and engaged in the activities. The group and individual actives are based on what the resident wants to do, the DT gave an example of one resident who does not like to participate in group activities, but enjoys knitting and cross words, and individual activities are organised for this resident. The DT reports that they discuss the weekly programme with the residents as they deliver the programme each Monday, and changes are made based on the residents interests. The DT reports that their good rapport with the residents is a strength of the activities programme. The residents’ meeting provides opportunities for the resident to provide feedback regarding the activities programme. The six of six residents express scarification with the activities programme.   There are church services weekly at the facility. Residents can access community activities, such as friendship groups and there are linkages with other local rest homes and child care services for shared activities and interactions.   The ARRC requirements are met. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| If a resident is not responding to the services or interventions being delivered, or their health status changes, then this is discussed with their GP. A short term care plan or changes to the long term care plan are initiated for issues such as, infections, wound care, changes in mobility and the resident's general condition. Wound treatment plans and updates to the resident's care plan regarding wound care are evidenced for the rest home resident reviewed and this is also developed for the hospital level of care residents, on the day of audit.   The care evaluations are documented on a separate 'evaluation' sheet. 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. The six of six residents report satisfaction with the care provided.   The ARRC requirements are met. |

##### **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.

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

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous corrective action request at 1.3.12.1 identified that there is no evidence to support that fridge temperatures are checked on a regular basis and meet required storage temperatures. The service now undertakes daily recording for the medicine fridge temperatures. This is now addressed and an area of improvement implemented since the last audit.   Medicines for residents are received from the pharmacy in the Medico Pak delivery system. A safe system for medicine management is observed on the day of audit. Medicines are stored in the treatment room in the care facility. The controlled drugs are stored in a safe in the medications room. The controlled drugs register records that the drugs are checked out by two staff and there is a weekly stock take recorded in the controlled drug register. Not all of the controlled drug weekly stock takes are recorded in red pen.   The 10 of 10 medicine charts reviewed are reviewed by the GP at least three monthly, with this review recorded on the medicine chart. The 10 of 10 medicine signing sheets are completed on the administration of medicines. The 10 of 10 medicine charts sighted have detailed prescriptions that contain the drug name, date, dose, time and route. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident. All the 10 medicine charts reviewed have each medicine signed individually by the GP and reviewed by the GP in the past three months.   There are no resident’s assessed as competent to self-administer their medicines at the time of audit. Metlifecare undertake a formal resident assessment before residents are able to self-administer their medicines.  All staff who administer medicines have a current medication competency, which includes insulin administration, that were completed in the past 12 months.  The ARRC 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.

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

##### **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.

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

##### **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.

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

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a 12 week menu, with seasonal variations, that is used across the Metlifecare facilities. The menu is reviewed by a dietitian, last reviewed in January 2014. The menu is reviewed using the NZ dietetics tool for the older person living in long term facilities.   A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. The nutritional profile is updated weekly, with serving staff given a daily sheet which has the menu and each resident’s choices. The additional nutritional requirements for the hospital level of care resident reviewed are identified by the kitchen staff.   Interviews with six of six residents and two of two family members confirm they are happy overall with the food and fluids provided.   All aspects of food procurement, production, preparation, storage, delivery and disposal complies with current legislation and guidelines. The service has a food safety plan based on the critical control points. Fridge and freezer recordings are undertaken daily and meet requirements. The food monitoring data is analysed by the management at least monthly, or more frequently if there is a concern. The kitchen staff have undertaken food safety management education appropriate to service delivery.    The ARRC 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.

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

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The physical environment is fit for purpose. The service has a current building warrant off fitness which expires in September 2014. |

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

All buildings, plant, and equipment comply with legislation.

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

#### Standard 1.4.6: Cleaning And Laundry Services **(**HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Chemicals are securely stored. The bathroom cleaning chemicals are on a specific high shelf inside a caged area and utility areas and the kitchen now have secure locks on the doors to prevent resident access. This was an area identified for improvement in the previous audit and is now fully attained. |

##### **Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)**

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The policy sighted states “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”.   The restraint register identifies that the service has two residents with bedside rails and chair lap belt restraints, four residents with just bedside rail restrains and three bedside rails which are enablers which are individually reviewed three monthly. Enablers in place allow residents to maintain independence with movement when in bed.  A six monthly quality review of all restraint use was undertaken in October 2013. (Refer comments in criterion 1.2.3.8 related to follow-up).   Interviews with the nurse manager/restraint co-ordinator, two RNs and five of five caregivers confirm their knowledge and understanding of restraint and enabler use. All staff confirm enablers are voluntary and the least restrictive option to keep residents safe and to allow maximum independence. |

##### **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.

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

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

#### Standard 3.3: Policies and procedures **(**HDS(IPC)S.2008:3.3)

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.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

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| **Attainment and Risk:** FA |
| **Evidence:** |
| At the request of the DHB the audit team is requested to further look into the policies and procedures around infection control, norovirus management and after hours communication with the hospital, family and DHB.  The policies sighted are clearly written and comply with relevant legislation and current accepted good practice. To ensure the provision of a service which is consistently safe the Infection Control Work Instructions have been developed to provide a reference and guide to ensure that best practice is followed at all times in the prevention and control of infections within Metlifecare, including residents and all other personnel. Associated documents include the use of a specialist infection control advisory services’ manual, resources and education as the expert advice for infection prevention and control matters. This manual covers the policies and procedures for the management of outbreaks, including gastroenteritis related illness. The service also has Public Health and Ministry of Health guidelines for outbreak management guidelines for gastroenteritis and guidelines specifically for management of Norovirus. The service implements actions based on the infection control manual and public health guidelines. The infection control officer has taken on the role of the outbreak manager. Families of residents in the care facility were first contacted through telephone communications and this was followed up either by email or written letter posted of the outbreak and the actions that are implemented. The service utilised the daily Norovirus outbreak case log, which was updated daily and faxed to Public Health and Metlifecare head office.   Signs and symptoms of nausea and vomiting of a single case commenced on 30 January 2014 (isolation precautions commenced for this resident). When a further two residents and two staff showed signs and symptoms of nausea and vomiting on 2 February 2014, the infection control coordinator was contacted and came into the service to act as the outbreak manager. The service was in ‘lock down’ from 2 February 2014 to 11 February 2014. Though the service was in lock down, they did accept two residents back from the acute care hospital during this time (9 and 10 February 2014), at the discretion of the infection control officer/outbreak manager and RN on duty. The services infection control manual does document that new residents should not be admitted to the facility until all cases have been free of symptoms for 48 hours. As these two residents were current residents of the service the outbreak manager decided to accept the two residents back on the 9 and 10 February 2014 concluding the period of higher risk had now passed.   The surveillance data and case logs record nine staff and 19 of the care facility residents showed signs and symptoms of nausea and vomiting over this time. Three resident stool specimens where sent for microbiology analysis, with these three confirming Norovirus. At the completion of the outbreak the service conducted a debriefing and evaluation of the event. The service identified areas for improvement from the analysis of the outbreak, these include ensuring village residents do not come into the care facility dining room, improved signage in the village, more formal notification to residents when the outbreak is finished, staff to choose what shower is to be the isolation shower, ensure that staff have access to commode chairs with a pan underneath, be clearer in the communication book for staff that the facility is still in lockdown, the development of information flyers for staff and making the meetings during the outbreak compulsory for all staff on duty (eg, caregivers, cleaning and kitchen staff). |

##### **Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)**

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

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

#### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Metlifecare organisational systems includes ensuring the infection control committees oversee and seek expert advice related to undertaking surveillance of infections to meet Health and Disability Services standard requirements related to the complexity of the facility. Policy states that expert and specialist advice is available from infection control specialists and a diagnostic service.   The infection control committee, with guidelines from Bug Control and the Metlifecare organisational polices, define the reporting requirements and determine the type of surveillance required. There is monthly surveillance reporting of infections at all staff meetings and at the quarterly Metlifecare national infection control meetings. The type of surveillance undertaken is appropriate to the size of the facility. The surveillance data is collated and analysed through the organisation’s Amrisk system. The data records that there is an increase of urinary tract infections (UTIs) during 5 December 2013 to 8 in January 2014. The IC coordinator reports that this is attributed to the increasing temperatures at this time of the year. Actions implemented include informal education through staff meetings, reminding the staff of the importance of encouraging fluids and effective hand washing. The service implemented an additional fluids round. The data for February 2014 is still being collected at the time of audit. Infections are reported to staff at handover (confirmed at interview) and residents with infections are started on short term care plans (sighted in the five of five residents’ files reviewed). |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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