Oceania Care Company Limited - Elmswood Home

Current Status: 25 September 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

Elmswood Home was providing dementia level care with a capacity of 38 beds. Occupancy on the day of audit was at 24 residents. The facility was operated by Oceania Care Company Limited.

There was a documented quality programme that included monitoring of complaints, incidents and accidents, health and safety and implementation of an internal audit programme.

There was a business and care manager who had been in the role for thirteen months who provided operational management over two sites with a clinical leader based on site. Staffing was appropriate to support the needs of residents requiring dementia level care.

Improvements required at the last two audits (certification and a partial provisional audit) around food services, hot water temperatures, laundry services, staff with first aid certificates, maintenance programme, call bell system and external environment have been met.

Improvements are required to specific risks identified at the audit around safety of chemicals, flooring, equipment maintenance and to advance directives.

Audit Summary as at 25 September 2014

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 25 September 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.

Organisational Management as at 25 September 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Continuum of Service Delivery as at 25 September 2014

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

Safe and Appropriate Environment as at 25 September 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Restraint Minimisation and Safe Practice as at 25 September 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Infection Prevention and Control as at 25 September 2014

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

HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

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

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

Audit Report

Legal entity name:	Oceania Care Company Limited
Certificate name:	Oceania Care Company Limited - Elmswood Home

Designated Auditing Agency:	Health Audit (NZ) Limited

Types of audit:	Surveillance Audit		
Premises audited:	Elmswood Home		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	**Start date:** 25 September 2014	**End date:**	25 September 2014

Proposed changes to current services (if any): Including Dementia Care

Total beds occupied across all premises included in the audit on the first day of the audit:	24

Audit Team

Lead Auditor	XXXXXXXX	**Hours on site**	7	**Hours off site**	5

Other Auditors	XXXXXXXX	Total hours on site	7	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	XXXXXXX			Hours	2.5

Sample Totals

Total audit hours on site	14	Total audit hours off site	11.5	Total audit hours	25.5

Number of residents interviewed	1	Number of staff interviewed	6	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	25	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

I, XXXXXXX, Managing Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health Audit (NZ) Limited	Yes
b)	Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health Audit (NZ) Limited 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)	Health Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Monday, 29 September 2014

Executive Summary of Audit

General Overview

Elmswood Home was providing dementia level care with a capacity of 38 beds. Occupancy on the day of audit was at 24 residents. The facility was operated by Oceania Care Company Limited.

There was a documented quality programme that included monitoring of complaints, incidents and accidents, health and safety and implementation of an internal audit programme.

There was a business and care manager who had been in the role for thirteen months who provided operational management over two sites with a clinical leader based on site. Staffing was appropriate to support the needs of residents requiring dementia level care.

Improvements required at the last two audits (certification and a partial provisional audit) around food services, hot water temperatures, laundry services, staff with first aid certificates, maintenance programme, call bell system and external environment have been met.

Improvements are required to specific risks identified at the audit around safety of chemicals, flooring, equipment maintenance and to advance directives.

Outcome 1.1: Consumer Rights

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family and complaints are investigated. Staff communicate with residents and family members following any incident.

An improvement is required to advance directives.

Outcome 1.2: Organisational Management

Elmswood Home has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from the business and care manager. Monthly business status reports allow monitoring of service delivery. Benchmarking reports are produced that include incidents/accidents, infections and complaints.

Staffing levels are adequate and interviews with a resident and relatives demonstrates that there is adequate access to staff to support residents when needed. The service is supported by the business and care manager who has leadership of two sites and a clinical leader.

Improvements required at the certification and partial provisional audit have been addressed around food services.

Outcome 1.3: Continuum of Service Delivery

Service provision within the organisation was undertaken by suitably qualified and experienced staff members. Health care services were provided within required time-frames and safely meet the needs of the residents. The service was coordinated in a manner that promotes continuity in service delivery and promoted a team approach with a handover observed confirming this.

Residents received adequate and appropriate services meeting their assessed needs and desired outcomes. Person centred care plans identified goals and interventions ensuring service delivery according to the needs of the residents.

Written activities were planned and displayed. Activities reflected the skills, strengths and the interests of the residents. Resident files showed person centred care plans being updated and reflecting changes in care.

Medication management provided safe and appropriate prescribing, review, storage, disposal and reconciliation of medicine. Medicines management training occurred three times during 2014. Staff members who were responsible for medicine management were competent to perform the function for each stage they manage. There were no residents who self-administered medicines. Medicine management information was recorded and adhered to legislative and other requirements. Allergies were identified and recorded. The controlled drugs were locked in a safe within a locked cupboard in the medicines room. The controlled drug register entries were in line with legislation and checked weekly. The pharmacist completed a six-monthly controlled drug stock-take. Medicines fridge temperatures were maintained and recorded.

The food, fluid and nutritional needs of residents were provided in line with recognised nutritional guidelines. The menu has been reviewed by a dietitian. The service employed a chef experienced in cooking for large numbers of people. The cook received duplicate dietary plans for new residents to ensure up to date information relating to the specific dietary needs of the residents. Fridge, freezer and food temperatures were monitored. Food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The areas requiring improvement from the last audit have been addressed.

Outcome 1.4: Safe and Appropriate Environment

The two wings operate independently and are secure with their own dining, lounge and ablution areas. There are outdoor areas that are secure for both wings. The maintenance staff operate across a sister site and Elmswood Home with checks in place. There is a current building warrant of fitness.

Improvements required at the certification and partial provisional audit have been addressed around electrical testing and tagging, hot water temperatures, laundry services, staff with first aid certificates, maintenance programme, call bell system and external environment.

Improvements are required to addressing specific risks identified at the audit around chemical safety, flooring and to equipment maintenance.

Outcome 2: Restraint Minimisation and Safe Practice

The service demonstrated that the use of restraint is minimised. There were no residents using enablers or restraints. Staff members have completed training related to restraint management, challenging behaviour and de-escalation management.

Outcome 3: Infection Prevention and Control

The service' infection control coordinator was responsible for collecting surveillance data monthly. Infection control surveillance included graphs and statistics to support management reports. Interviews and meeting minutes confirmed feedback to the quality committee and at staff meetings. The service maintained an infection surveillance register and participated in benchmarking.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	17	0	2	1	0	0
Criteria	0	44	0	2	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	30
Criteria	0	0	0	0	0	0	0	54

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.7	Advance directives that are made available to service providers are acted on where valid.	PA Low	Family members are making the 'not for resuscitation' decision.	Ensure that the advance directives are signed only by the resident deemed competent to make such decisions.	60
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		are fit for their purpose.				
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Moderate	i) There is a carpet in one room that is soaked in urine with a smell permeating the hallway despite cleaning at least once a day with a wet vac (checked at 0900 and 1330 noting that the floor remains damp for a period of time after cleaning), and iii) lack of foot pedals for one wheelchair with a resident dragging feet while being pushed by a staff member.	Ensure that carpets are kept clean and dry with a pleasant smell in the facility. Ii) Ensure that equipment is maintained.	30
HDS(C)S.2008	Standard 1.4.6: Cleaning And Laundry Services	Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	PA Low			
HDS(C)S.2008	Criterion 1.4.6.3	Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Low	The sluice room is left ajar on two occasions with chemicals in the room.	Ensure that chemicals are kept in a secure place at all times.	30

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

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

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

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

Attainment and Risk: FA

Evidence:

Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, evidenced eight of ten completed accident/incident forms noting that two did not require family to be notified.

Family contact is recorded in residents' files – sighted in five of five files reviewed.

Interviews with five family members confirm they are kept informed. Family also confirm that they are invited at least six monthly to the care planning meetings/MDT (multi-disciplinary team meetings) for their family member.

Family interviewed confirm that they are invited to speak with the business and care manager and or clinical manager whenever they wish.

Interpreter services are available when required from the District Health Board and the staff use family members to interpret when needed. There are no residents requiring the use of interpreting services currently.

The information pack is available in large print and advised that this can be read to residents and family as required.

Staff have had training around communication in August 2013.

A review of five files indicates that all have a documented communication forms that inform staff of family engagement with the service.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: PA Low

Evidence:

There is a policy around choice, consent and advance directives.

Consents are signed for photo identification, outings, information sharing and treatment. Residents are not competent to complete advanced directives. Family sign the advance directives with the service mitigating risk by deleting the ‘not for resuscitation’ instructions by family members.

An improvement is required to advance directives.

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: PA Low

Evidence:

Consents are signed for photo identification, outings, information sharing and treatment. Residents are not competent to complete advanced directives.

Finding:

Family members are making the 'not for resuscitation' decision.

Corrective Action:

Ensure that the advance directives are signed only by the resident deemed competent to make such decisions.

Timeframe (days): 60 *(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

Attainment and Risk: FA

Evidence:

The organisation's complaints policy and procedures is in line with the Code and includes time-frames for responding to a complaint. Complaint's forms are available at the entrance.

A complaints register is in place and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint's folder.

Two complaints lodged in 2014 are reviewed. All are documented on the complaints register with all signed off stating that they are resolved. Any letters to the complainants are kept on file and all indicate that they are reviewed with the complainant informed within timeframes as per policy.

The information pack includes comprehensive information around dementia with five of five family members stating that this is useful in guiding their interactions and understanding of behaviour and needs. The information includes the service philosophy and practices particular to the unit including the need for a safe environment for self and others, how behaviours different from other residents are managed and specifically designed and flexible programmes, with an emphasis on behaviour management and the complaints policy.

All resident admission agreements are signed on the day of admission.

The District Health Board 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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

Attainment and Risk: FA

Evidence:

Oceania Care Company Limited (Oceania) is the governing body and is responsible for the service provided at Elmswood Home. The Oceania quality and risk management systems are implemented at Elmswood Home and the documented scope, direction, goals, vision, values, mission statement and philosophy are reviewed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

Systems for monitoring the service including regular monthly reporting by the business and care manager (BCM) and the clinical leader (CL) to Oceania support office via the Oceania intranet are in place. Reporting includes reporting on quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators. Monthly business status reports are provided to the Oceania executive team and link to the organisations business plan.

The BCM is an experienced health manager and has been in this position for 13 months. The BCM also manages Melrose Park which is another Oceania facility in Tauranga. The BCM, who is not a registered nurse but has audited in health for an accounting service, has eight years' experience in aged care. The business and care manager is supported in their role by a clinical leader (CL) who was appointed to this position in January 2014. They are supported by an Oceania clinical and quality manager as well as a regional operations manager from Oceania. The CL has a current practising certificate. The BCM and CL's personal files are reviewed and there is documented evidence they attend education to keep themselves up-to-date.

Elmswood Home is currently certified to provide dementia level care. During this audit there are 24 residents assessed as requiring dementia level care in the 38-bed facility.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Elmswood Home uses the Oceania quality and risk management framework that is documented to guide practice. The business plan is documented and reported on through the business status reports. This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incidents, relationships and market presence action plan and review of physical products.

The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to stay that they have read and understood – sighted and confirmed by the two health care assistants interviewed.

Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues. Staff receive feedback and have input into the quality improvement programme though monthly meetings that include staff meetings, registered nurse, household and quality. Meeting minutes reviewed indicate that all aspects of the quality programme is reviewed.

All staff interviewed including two health care assistants, the diversional therapist, registered nurse, clinical leader and the business and care manager report they are kept informed of quality improvements.

There are annual family/resident satisfaction surveys which last took place in March 201 (note the clinical leader confirms that there were residents able to participate in the

survey identified as rest home level care – the service no longer has residents identified as being at rest home level care). The 2014 action plan is documented and recommendations implemented.

The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures, and a health and safety plan are in place for the service. There is a hazard management programme documented 2014 with a hazard register documented. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated. There are health and safety goals and monthly reports documented by the health and safety officer who is based at Melrose with two representatives at the Elmswood Home site.

The organisation holds a current ACC Work Safety and Management Practice tertiary level accreditation to March 2015 with six monthly ACC health and safety management plan reviews and action plans documented.

There is a six to eight weekly Community Connect newsletter from the organisation. This keeps residents up to date with changes in the service and wider organisation.

The service is able to show quality improvements that are aimed at improving the lives of residents. Residents, family and the general practitioner interviewed confirm a high level of satisfaction with the service.

The District Health Board contract 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

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

Attainment and Risk: FA

Evidence:

The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There has been an outbreak of scabies in June 2014 and relevant authorities are notified including the public health unit who came and talked with staff in June 2014 and verbally to the District Health Board as stated by the business and care manager and the clinical leader.

The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the clinical leader, business and care manager and clinical and quality manager who operates over a number of services.

Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.

Ten incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for eight of ten recorded events with two not requiring family to be notified.

Information gathered is regularly shared at the monthly executive management and regional meetings with the business and care manager documenting incidents which are then graphed, trends analysed and benchmarking of data occurring.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The clinical leader (CL) is providing oversight of the in-service education programme at Elmswood Home The clinical leader at Elmswood Home has responsibility for the education programme for both sites in conjunction with the clinical manager at Melrose.

The BCM advises an annual education plan is developed that is based on the Oceania education plan and that in-service education sessions are provided at least once a week. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via the Oceania Certificate in Residential Care programme and the 14 health care assistants (HCAs) currently working in the dementia unit have completed the dementia specific unit standards. One has recently been employed and has in the past completed the ACE dementia training.

Orientation occurs on a single day where the clinical leader and business and care manager organise for all topics to be included. This is described as working well and in 2015 the two sites are moving to a having a day of training for staff that will include annual requirements including competencies. In-service education plans, staff competency registers and staff education records are maintained and are reviewed for 2014.

The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority and are reviewed on staff files (five of five) along with employment agreements, criminal vetting, completed orientations and competency assessments. Individual records of education are maintained for each staff member.

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, dietitian, pharmacist, and general practitioners (GPs) is occurring. An appraisal schedule is in place and current staff appraisals sighted on staff files reviewed.

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

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

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

Attainment and Risk: FA

Evidence:

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum number of health care assistants at any time is two with a short shift providing support in the morning (Tui wing with 16 residents currently occupying an 18 bed unit) and one at all times in Kotuku unit. There are plans in place to increase staffing as numbers of residents increases.

There is registered nurse cover seven days a week with the clinical leader/registered nurse working full time Monday to Friday as well.

Some staff share roles at Melrose (sister site across the road) and Elmswood Home including the maintenance staff, business and care manager. Laundry and kitchen services are provided from Melrose and transported across the road.

There are a total of 25 staff including the business and care manager, clinical leader, two registered nurses, two cleaners, diversional therapist, activities assistant, receptionist and 15 health care assistants.

Care staff interviewed report there is adequate staff available and that they are able to get through the work allocated to them. Family members (five) interviewed report there is enough staff on duty to provide them with adequate care. Visual observations during this audit confirm adequate staff cover is provided.

The District Health Board requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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

Attainment and Risk: FA

Evidence:

The stages of service provision are undertaken by suitably qualified and experienced staff members. Interview with the clinical leader confirms knowledge and understanding dementia level of care. Service provision is consistent to safely meet the needs of residents however the resuscitation decision 'not for resuscitation' is currently made by family members.

The service has systems in place showing that each stage of service delivery is coordinated to promote continuity of service. Staff training records appropriate qualifications and or experience. Staff interviews confirm they are trained and competent to perform their expected tasks. Medicines management competencies are current. Family interviews confirm they have input into the care planning and adverse events are communicated. A handover observed indicates that there is continuity of care provided between staff coming on to the next shift.

Tracer methodology:

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

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Reviewed resident files are easily identifiable, initial care plans are in place, admission agreements are signed and dated, next of kin are identified and where a resident have an enduring power of attorney identified the service holds legal documentation in support

Progress notes are legible, dated and actual time is recorded. Staff members make entries to the progress notes, sign and identify their designation, during every shift. The service record risk assessments including falls, skin, challenging behaviour, wounds, continence pain, cultural, activities, mobility and nutrition. The individual care plans include goals, interventions and six monthly reviews. There is evidence of residents and or their family making input into care planning. Vital signs are recorded for residents and they have their weight monitored on a monthly basis.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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

Attainment and Risk: FA

Evidence:

Activities are planned and provided to maintain skills and interests of the residents. Interview with a resident and family members confirm they enjoy and participate in activities. The diversional therapist provides specialised activities with a focus on the needs of people who have dementia.

Activities are planned with the resident's abilities and interests in mind. The diversional therapist is also responsible for the activities at another facility and has an assistant who is currently completing the diversional training course. Activity plans are reviewed six monthly, verified in five resident files (three in the Tui wing and two in the Kotuku wing). Residents' attendance is recorded. All residents have a management plan for 'behaviour that challenges' with strategies for de-escalation of and the management of challenging behaviour.
The District Health Board contract 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Resident reviews are documented and specific to the current status of the resident and care plans reflect findings as identified in the risk assessments.
Five resident files reviewed, three in the Tui wing and two in the Kotuku wing. Where the progress of the resident is different from what is expected, the service acts by reviewing and changing the person centred care plans to reflect current abilities.
District Health Board contract 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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

Attainment and Risk: FA

Evidence:

Medicine management information is recorded to a level of detail that complies with legislation and guidelines. Ten medicine charts are reviewed, six from the Tui wing and four in the Kotuku wing. The records are legible, doctor's reviews are completed every three months and each entry is signed and dated. Discontinued medicines are signed and dated and all residents have their allergy status identified. The residents' medicine charts all have photo identification and medicines reconciliation takes place for all new residents or residents that return to the service after hospitalisation.

The controlled drugs are kept in a locked safe in a locked medicines cupboard. Controlled drug entries into the drug register are checked weekly by registered nurses and the pharmacy does a six monthly drug stock-take of controlled drugs, verified. The medicines fridge temperatures are checked weekly and a random sample of medicines expiry dates show medicines are within the required use-by dates. The service has a process for returning medicines to the pharmacy which includes keeping the medicines in a plastic container in the locked drug room with a 'return to pharmacy record' completed for daily returns.

The clinical leader confirms that there are no residents who self-administer medicines. Medicines competencies are recorded for 11 health care assistants and three registered nurses, sighted. Medicines management training occurred on 9 April, 7 May and 27 August 2014. Observation of a medication round confirms that staff follow policies and procedures.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Food, fluid and nutritional needs of residents are provided in line with recognised guidelines that are appropriate to the residents' needs as described by the chef interviewed. The menus were reviewed by a company dietitian during May 2014.

Residents who have specific or additional nutritional needs have these needs met. The chef receives a copy of the dietary profile, completed on admission and when the residents' needs change. Food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.

Food stores are well stocked and tidy. Resident's food preferences are identified and written on the chef's white board in the main kitchen to ensure it is adhered to. Food temperatures are monitored at each mealtime (at the time of leaving the kitchen and at the time of dishing up) to ensure food stays hot during transport from the main kitchen.

Two improvements required at the previous audit have been addressed. Evidence of food safety training for the chef is sighted in 2014 and the vegetable storage shelves have been repaired and are no longer an infection control issue.

The residents interviewed state that the food is well prepared, hot and tasty and family interviewed also confirm this. The residents and family also completed a food service survey with this indicating that the food is satisfactory.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

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

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

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

Attainment and Risk: PA Moderate

Evidence:

There are two wings (both secure units that operate as secure units) on site for residents requiring dementia level care. The wings are identified as Tui and Kotuku. The units have a common reception area.

The business and care manager confirms there is a reactive maintenance programme in place and regular building inspections according to the service /maintenance inspection sheets for the building warrant of fitness requirements. There is recorded evidence of a preventative maintenance plan that includes external areas and equipment. The improvement required at the previous audit has been met.

The business and care manager confirms the maintenance staff member is employed full time between Melrose Park and Elmswood Home.

Medical equipment checks were conducted by an external contractor in January 2014. There is safe storage of medical equipment, sighted. Testing and tagging is completed one to two yearly and is current.

Building Warrant of Fitness expires 3 May 2015.

Corridors are wide enough to allow residents to pass each other safely. Safety rails are secure and are appropriately located. Floor surfaces/coverings are appropriate to the resident group and setting.

Staff receive education in the safe use of medical equipment and there is a system in place to review staff competency for specific equipment; for example hoists competency. This was confirmed at four of four clinical staff interviews (one registered nurse, clinical leader and two health care assistants) and review of staff education records.

There are two external areas. One external area located by the lounge is comprised of a cobblestone area, a pathway and gardens and lawns either side of the pathway. The area is secure and the service is continuing to put garden furniture into the area (currently there is seating and shade). There are six exit/entry doors into the secure building.

There is another large external area off Tui wing that has gardens, a circular path, bus stop and other interesting features. The garden/path is enclosed by a fence with two exit/entry points into the building.

There is a deck extending from the dining room. The deck is approximately six metres by five metres and is surrounded by a fence. Permanent seating is now situated within away from fencing and the air conditioning unit that was once by the fence has been moved away. The garden area has been raised to the height of the path and there is a ramp with non-slip edging. There is shade and seating. There are two doors into the building. The improvement required at the previous audit has been met.

The improvements required at the previous audits to the maintenance plan, courtyard and checking of electrical equipment have been met.

Improvements are required to the carpet in one room and the subsequent smell in the facility and to equipment maintenance.

The District Health Board contract requirements are partially met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Moderate

Evidence:

There is flooring appropriate to the needs of the residents in all areas. There is equipment available for residents to meet their requirements.

Finding:

i) There is a carpet in one room that is soaked in urine with a smell permeating the hallway despite cleaning at least once a day with a wet vac (checked at 0900 and 1330 noting that the floor remains damp for a period of time after cleaning), and iii) lack of foot pedals for one wheelchair with a resident dragging feet while being pushed by a staff member.

Corrective Action: i) Ensure that carpets are kept clean and dry with a pleasant smell in the facility. **I**i) Ensure that equipment is maintained.

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

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA

Evidence:

Hot water is monitored. Temperature checks are completed monthly by the maintenance staff member. Records of water temperature checks are sighted and show that hot water is provided at a consistently safe temperature. The improvement required at the previous audit is met.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.6: 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

Attainment and Risk: PA Low

Evidence:

All laundry takes place at Melrose with a process in place to ensure that laundry is taken from Elmswood Home and delivered back on site in a timely and efficient manner. A procedure for the management of laundry processes is documented and the service monitors effectiveness of the system through the internal audit programme with audits completed in March and September 2014. As per the corrective action planning process, any issues identified are addressed with review by the clinical leader and the business and care manager. The improvement required at the previous audit is met.

Chemicals are stored in a room that can be locked.

An improvement is required to ensuring that chemicals are locked away.

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.6.3 (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.

Attainment and Risk: PA Low

Evidence:

There are rooms that can be locked to keep chemicals safe.

Finding:

The sluice room is left ajar on two occasions with chemicals in the room.

Corrective Action:

Ensure that chemicals are kept in a secure place at all times.

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

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Attainment and Risk: FA

Evidence:

Training on emergency management is provided to all staff in orientation and then in an on-going manner. This includes an emergency situations quiz and checklist. Nurse competencies include emergency medical procedures.

There are always staff on duty with a first aid certificate (confirmed through review of rosters and confirmation from the clinical leader and the business and care manager) with the last first aid training provided in June 2014.

An audit on first aid certificates is conducted last in June 2014 to ensure there is a first aider on each shift. The results of the audit is sighted and confirms current certificates for the clinical leader, diversional therapist, administrator and health care assistants. The improvement required at the previous audit is met.

There is evidence that call bells are fixed as required with six monthly routine checks included in the maintenance schedule. A tour of the facility indicates that each room has a call bell with those randomly checked by the auditor showing that these are operational. The improvement required at the previous audit has been met.

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Visual inspection of the site confirms there is no evidence of restraints or enablers being used. Five resident files reviewed, interview with family and with the general practitioner confirm residents are restraint free.

Challenging behaviour is managed through the implementation of de-escalation techniques. Interviews with staff confirm they receive training in relation to challenging behaviour management and de-escalation techniques. Challenging behaviour training occurred on 9 April 2014, 24 September 2014, de-escalation training occurred on 9 July 2014 and restraint training occurred on 12 February 2014.

Five resident files reviewed show person centred care plans reflect their ‘no restraint’ policy.
The District Health Board contract requirement is met.

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

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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 3.5: Surveillance (HDS(IPC)S.2008:3.5)

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

Attainment and Risk: FA

Evidence:

The service is appropriate for the size and complexity of the organisation. The infection control coordinator has a signed job description for the role and they maintain an infection control register for surveillance, verified. The infection control register records when the infection occurred, the type of infection, the treatment given and laboratory results. The records also reflect whether the antibiotics were effective or not, when the infection was resolved and the total number of days the infection lasted. Infections are reflected in graphs that compare the monthly infection rates.

The service has an infection control committee that reports to the health and safety meeting and the monthly quality meeting. Infection control training includes an opportunity for the infection control coordinator to attend a focus group where presenters offer training for the infection control coordinators of the different regional facilities. The training content is then reported at the infection control committee meetings. Infection control training occurred on 22 January; 4 June and 11 June 2014.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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