**Metlifecare Coastal Villas Limited**

**Current Status:** **20-Aug-13**

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

**General overview**

Metlifecare Coastal Villas is a 35 bed hospital and rest home that adjoins a village complex. Five apartments are used for rest home care only. There are 30 hospital beds and seven of these beds can accommodate either hospital or rest home residents. The facility is owned by Metlifecare Coastal Villas Limited. On the day of this audit 30 hospital and two rest home beds are occupied.

The nurse manager, who has been in the role for 10 months is experienced in aged care. She is supported by a village manager who looks after non-clinical areas, such as maintenance, gardening, and the village areas. Both managers hold current nursing practising certificates. On the days of audit the organisation was represented by the Metlifecare clinical quality and risk manager. Metlifecare's management team are available for support and advice as required.

Eight areas are identified as requiring improvement in this audit. Six areas relate to service delivery, one to providing a safe environment and one to management of restraint.

**Audit Summary AS AT** **20-Aug-13**

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 |

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| **Consumer Rights** | Day of Audit20-Aug-13 | Assessment |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | **Standards applicable to this service fully attained** |

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| **Organisational Management** | Day of Audit20-Aug-13 | Assessment |
| 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** |

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| **Continuum of Service Delivery** | Day of Audit20-Aug-13 | Assessment |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| **Safe and Appropriate Environment** | Day of Audit20-Aug-13 | Assessment |
| 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 low risk** |

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| **Restraint Minimisation and Safe Practice** | Day of Audit20-Aug-13 | Assessment |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | **Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk** |

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| --- | --- | --- |
| **Infection Prevention and Control** | Day of Audit20-Aug-13 | Assessment |
| 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** |

**Audit Results AS AT** **20-Aug-13**

**Consumer Rights**

Metlifecare Coastal Villas provides information and discussion on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) to ensure residents and their families understand their rights and are able to raise concerns and access support services.

The management and staff have a commitment to open disclosure and transparency in all service provision. Residents' cultural and individual values and beliefs are assessed on admission and documented in the plan of care. Staff receive education on supporting cultural and individual values and beliefs at orientation and through the annual education programme. Interviews with residents, staff and relatives, and observations, confirm that privacy is respected.

Information on informed consent is provided in the residents' admission pack. The registered nurse discusses general consents with the resident and family on admission. Metlifecare's informed consent policy outlines recording requirements and the information to be provided.

Metlifecare's concerns, complaints and suggestions policy has clear guidelines for staff when receiving any complaint. Time frames for the acknowledgement, investigation and closure of a complaint are in line with Right 10 of the Code. The service has a complaints register which shows that complaints are followed up appropriately. All complaints are clearly recorded. This was an area identified for improvement in the previous audit and is now fully attained. At the time of audit there are three outstanding complaints. One complaint received has been investigated by the District Health Board and relates to activities. This is being well managed by the facility. Two complaints received in August 2013 have been acknowledged in writing to the complainant and follow-up is being completed by the nurse manager.

**Organisational Management**

Organisational structures and processes are monitored at organisational level via a computer system known as Amrisk. Service performance is aligned with the organisation's philosophy and goals as identified in the Metlifecare Coastal Villas site specific business plan. Quarterly monitoring of set goals are reported on by management at organisational level.

The nurse manager is suitably qualified, with delegated authority, accountability and responsibility for the provision of service.

Key components of service delivery, infection control, health and safety, restraint, complaints management and adverse event reporting, are explicitly linked to the organisational quality system. Documentation identifies that implementation and follow up of corrective actions is undertaken as required. Regular audits and reporting systems are in place to identify any service deficits. All identified deficits are addressed via a corrective action process and used to improve services as appropriate.

There is an up to date risk register which outlines controls that are in place to minimise actual and potential risks.

All incidents, accidents and untoward events are reported, recorded, evaluated and benchmarked. A review of residents' files and resident and family/whanau interviews confirm adverse events are reported and discussed in an open and honest manner.

Staffing levels are monitored at organisational level to ensure safe staffing levels and skill mix requirements are met. Human resources management processes in place meet policy requirements. Staff education is planned, reviewed, monitored and evaluated to ensure it is relevant to service provision.

Resident information is uniquely identifiable, current and stored in a manner that ensures confidentiality. Information is easily accessible when required.

**Continuum of Service Delivery**

All residents who enter Metlifecare Coastal Villas are appropriately assessed by the Needs Assessment and Service Coordination (NASC) as requiring hospital or rest home level of care. Residents receive timely, competent and appropriate service delivery from staff who are trained according to their role.

Lifestyle plans are developed through a multidisciplinary approach to care planning and service provision, however a lack of co-ordination and planning in some clinical areas of service have identified four areas requiring improvement.

The lifestyle plans are evaluated at least three monthly by the registered nurse. Clinical notes are integrated and resident focused with input from all providers involved in the resident's care. Exit, discharge or transfer from the service is planned and co-ordinated and includes the identification of known risks.

Group and individual activity plans are developed by the activities co-ordinator with diversional therapy input to reflect the resident's identified needs and preferences.

Medicine management systems implemented comply with current legislative requirements, however an area requiring improvement is identified around medication administration.

Residents' nutritional needs are provided by a contracted service and the menu is reviewed to comply with guidelines for the older person in long term residential care. An area requiring improvement is identified around the recording of fridge temperatures and food storage in residents' fridges.

**Safe and Appropriate Environment**

Emergency planning, policies and processes are implemented by the service to ensure residents, visitors and staff are protected from harm as a result of exposure to waste or infectious substances generated during service delivery.

The facility provides residents with an appropriate environment for hospital and rest home level care. All bedrooms are single occupancy. Hospital level care bedrooms have an ensuite toilet and hand basin and rest home level care apartments have full ensuite facilities. There are adequate numbers of shower facilities which are centrally located. There are two dining areas and a large lounge area. Residents can also access the village lounge and dining areas if they choose. Medical equipment is checked at least annually. Electrical equipment testing is overdue and this is an area identified for improvement.

Emergency and security responses are well documented and understood by staff. Six monthly fire evacuations and emergency education is undertaken. The service has an approved fire evacuation plan. There are adequate emergency supplies, including food and water.

The building has a current building warrant of fitness. There is an appropriate system implemented for reactive maintenance. The facility is electrically heated via under floor heating and is ventilated through opening windows. There are suitable outdoor areas that have seating and shelter for residents' use.

**Restraint Minimisation and Safe Practice**

At the time of audit, Metlifecare Coastal Villas has three bed side rail enablers and two restraints (one bedside rail and one chair lap belt) in use. The definition of an enabler meets Health and Disability Services Restraint Minimisations and Safe Practice Standards. Policies and procedures cover all aspects of restraint use and are available to all staff. Clinical staff complete restraint education as part of the orientation process and as regular on-going education.

Assessment processes fully inform care planning. Restraint is only used for safety reasons and this is fully understood by clinical staff. There is a system in place to inform staff and management when the next assessment is due. Restraint is discontinued as appropriate.

Restraint use is evaluated three monthly for individual residents, however there is an improvement required to ensure restraint evaluation identifies actions to be taken to gain the desired outcome of keeping residents safe.

A full quality review is undertaken bi-annually to ensure the least restrictive type of restraint is being used and that policy is being complied with. Restraint use is reported at all levels of the organisation, as confirmed in meeting minutes sighted. Resident and family/whanau input is well documented in relation to all restraint and enabler use as appropriate.

**Infection Prevention and Control**

The Metlifecare organisation wide infection prevention and control programme is implemented by the infection prevention and control nurse at

Metlifecare Coastal Villas. An external contractor provides the organisation wide infection control policies. There are adequate resources to allow for a managed environment which minimises the risk of infection to residents, staff and visitors.

The infection prevention and control nurse has the responsibility to ensure the surveillance methods are adhered to and monthly infection surveillance data are recorded, collated and reported to management, who enters the data into a company wide data base. Analysis and evaluation of benchmarked data is undertaken by the service and corrective actions required are actioned in a timely manner, to assist in lowering infection rates.

Metlifecare Coastal Villas

Metlifecare Coastal Villas Limited

Certification audit - Audit Report

Audit Date: 20-Aug-13

Audit Report

To: HealthCERT, Ministry of Health

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| --- | --- |
| **Provider Name** | Metlifecare Coastal Villas Limited |

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| --- | --- | --- | --- |
| **Premise Name** | **Street Address** | **Suburb** | **City** |
| Metlifecare Coastal Villas | 100 Rimu Rd | Raumata Beach | Paraparaumu |

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| **Proposed changes of current services** (*e.g. reconfiguration*)**:** |
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| --- | --- |
| **Type of Audit** | Certification audit and (*if applicable*)  |
| **Date(s) of Audit** | **Start Date:** 20-Aug-13 **End Date:** 21-Aug-13 |
| **Designated Auditing Agency** | The DAA Group Limited |

# Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Audit Team | Name | Qualification | Auditor Hours on site | Auditor Hours off site | Auditor Dates on site |
| Lead Auditor | XXXXXXX | RCN, BA, Lead Auditor 8086 | 16.00 | 8.00 | 20-Aug-13 to 21-Aug-13 |
| Auditor 1 | XXXXXXX | NZRN, NZQA8086 | 16.00 | 8.00 | 20-Aug-13 to 21-Aug-13 |
| Auditor 2 |       |       |       |       |       |
| Auditor 3 |       |       |       |       |       |
| Auditor 4 |       |       |       |       |       |
| Auditor 5 |       |       |       |       |       |
| Auditor 6 |       |       |       |       |       |
| Clinical Expert |       |       |       |       |       |
| Technical Expert |       |       |       |       |       |
| Consumer Auditor |       |       |       |       |       |
| Peer Review Auditor | XXXXXXX | RN,MBA,NZQA 8086 |       | 4.00 |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Audit Hours on site** | 32 | **Total Audit Hours off site** *(system generated)* | 20 | **Total Audit Hours** | 52 |
| **Staff Records Reviewed** | 8 of 45 | **Client Records Reviewed** *(numeric)* | 10 of 32 | **Number of Client Records Reviewed using Tracer Methodology** | 2of 10 |
| **Staff Interviewed** | 14 of 45 | **Management Interviewed** *(numeric)* | 3 of 3 | **Relatives Interviewed** *(numeric)* | 4 |
| **Consumers Interviewed** | 7 of 32 | **Number of Medication Records Reviewed** | 12 of 32 | **GP’s Interviewed (aged residential care and residential disability)** *(numeric)* | 1 |

# Declaration

I, (full name of agent or employee of the company) XXXXXXX (occupation) Director of (place) Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that The DAA Group Limitedhas in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 19 day of September 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit: 🗷

The audit summary has been developed in consultation with the provider: 🗷

Electronic Sign Off from a DAA delegated authority (*click here*): 🗷

# Services and Capacity

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| --- | --- | --- | --- | --- |
|  |  |  |  | **Kinds of services certified** |
|  |  |  | Hospital Care | Rest Home Care | Residential Disability Care |
| **Premise Name** | **Total Number of Beds** | **Number of Beds Occupied on Day of Audit** | **Number of Swing Beds for Aged Residen-tial Care** |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Metlifecare Coastal Villas | 35 | 32 | 7 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 | 🗷 | 🞏 | 🞏 | 🞏 | 🞏 | 🞏 |
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Executive Summary of Audit

General Overview

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The building has a current building warrant of fitness. There is an appropriate system implemented for reactive maintenance. The facility is electrically heated via under floor heating and is ventilated through opening windows. There are suitable outdoor areas that have seating and shelter for residents' use.

2 Restraint Minimisation and Safe Practice

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Restraint use is evaluated three monthly for individual residents, however there is an improvement required to ensure restraint evaluation identifies actions to be taken to gain the desired outcome of keeping residents safe.

A full quality review is undertaken bi-annually to ensure the least restrictive type of restraint is being used and that policy is being complied with. Restraint use is reported at all levels of the organisation, as confirmed in meeting minutes sighted. Resident and family/whanau input is well documented in relation to all restraint and enabler use as appropriate.

3. Infection Prevention and Control

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Metlifecare Coastal Villas. An external contractor provides the organisation wide infection control policies. There are adequate resources to allow for a managed environment which minimises the risk of infection to residents, staff and visitors.

The infection prevention and control nurse has the responsibility to ensure the surveillance methods are adhered to and monthly infection surveillance data are recorded, collated and reported to management, who enters the data into a company wide data base. Analysis and evaluation of benchmarked data is undertaken by the service and corrective actions required are actioned in a timely manner, to assist in lowering infection rates.

Summary of Attainment

* 1. Consumer Rights

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.1.1 | Consumer rights during service delivery | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.2 | Consumer rights during service delivery | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.3 | Independence, personal privacy, dignity and respect | FA | 0 | 4 | 0 | 0 | 0 | 7 |
| Standard 1.1.4 | Recognition of Māori values and beliefs | FA | 0 | 3 | 0 | 0 | 0 | 7 |
| Standard 1.1.5 | Recognition of Pacific values and beliefs |   | 0 | 0 | 0 | 0 | 0 | 2 |
| Standard 1.1.6 | Recognition and respect of the individual’s culture, values, and beliefs | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.1.7 | Discrimination | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.1.8 | Good practice | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.1.9 | Communication | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.1.10 | Informed consent | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 1.1.11 | Advocacy and support | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.1.12 | Links with family/whānau and other community resources | FA | 0 | 2 | 0 | 0 | 0 | 2 |
| Standard 1.1.13 | Complaints management | FA | 0 | 2 | 0 | 0 | 0 | 3 |

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| Consumer Rights Standards (of 12): N/A:0 CI:0 FA: 12 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 48): CI:0 FA:23 PA:0 UA:0 NA: 0 |

* 1. Organisational Management

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.2.1 | Governance | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.2.2 | Service Management | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.2.3 | Quality and Risk Management Systems | FA | 0 | 8 | 0 | 0 | 0 | 9 |
| Standard 1.2.4 | Adverse event reporting | FA | 0 | 2 | 0 | 0 | 0 | 4 |
| Standard 1.2.5 | Consumer participation |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 1.2.6 | Family/whānau participation |   | 0 | 0 | 0 | 0 | 0 | 3 |
| Standard 1.2.7 | Human resource management | FA | 0 | 4 | 0 | 0 | 0 | 5 |
| Standard 1.2.8 | Service provider availability | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 1.2.9 | Consumer information management systems | FA | 0 | 4 | 0 | 0 | 0 | 10 |

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| Organisational Management Standards (of 7): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 34): CI:0 FA:22 PA:0 UA:0 NA: 0 |

* 1. Continuum of Service Delivery

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.3.1 | Entry to services | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.2 | Declining referral/entry to services | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.3 | Service provision requirements | PA Low | 0 | 2 | 1 | 0 | 0 | 6 |
| Standard 1.3.4 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.3.5 | Planning | PA Moderate | 0 | 1 | 1 | 0 | 0 | 5 |
| Standard 1.3.6 | Service delivery / interventions | PA Low | 0 | 0 | 1 | 0 | 0 | 5 |
| Standard 1.3.7 | Planned activities | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.3.8 | Evaluation | PA Moderate | 0 | 1 | 1 | 0 | 0 | 4 |
| Standard 1.3.9 | Referral to other health and disability services (internal and external) | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.10 | Transition, exit, discharge, or transfer | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.3.11 | Use of electroconvulsive therapy (ECT) |   | 0 | 0 | 0 | 0 | 0 | 4 |
| Standard 1.3.12 | Medicine management | PA Low | 0 | 3 | 1 | 0 | 0 | 7 |
| Standard 1.3.13 | Nutrition, safe food, and fluid management | PA Low | 0 | 2 | 1 | 0 | 0 | 5 |

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| --- |
| Continuum of Service Delivery Standards (of 12): N/A:0 CI:0 FA: 6 PA Neg: 0 PA Low: 4 PA Mod: 2 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 51): CI:0 FA:15 PA:6 UA:0 NA: 0 |

* 1. Safe and Appropriate Environment

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 1.4.1 | Management of waste and hazardous substances | FA | 0 | 2 | 0 | 0 | 0 | 6 |
| Standard 1.4.2 | Facility specifications | PA Low | 0 | 2 | 1 | 0 | 0 | 7 |
| Standard 1.4.3 | Toilet, shower, and bathing facilities | FA | 0 | 1 | 0 | 0 | 0 | 5 |
| Standard 1.4.4 | Personal space/bed areas | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 1.4.5 | Communal areas for entertainment, recreation, and dining | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 1.4.6 | Cleaning and laundry services | FA | 0 | 2 | 0 | 0 | 0 | 3 |
| Standard 1.4.7 | Essential, emergency, and security systems | FA | 0 | 5 | 0 | 0 | 0 | 7 |
| Standard 1.4.8 | Natural light, ventilation, and heating | FA | 0 | 2 | 0 | 0 | 0 | 3 |

|  |
| --- |
| Safe and Appropriate Environment Standards (of 8): N/A:0 CI:0 FA: 7 PA Neg: 0 PA Low: 1 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 36): CI:0 FA:16 PA:1 UA:0 NA: 0 |

1. Restraint Minimisation and Safe Practice

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 2.1.1 | Restraint minimisation | FA | 0 | 1 | 0 | 0 | 0 | 6 |
| Standard 2.2.1 | Restraint approval and processes | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 2.2.2 | Assessment | FA | 0 | 1 | 0 | 0 | 0 | 2 |
| Standard 2.2.3 | Safe restraint use | FA | 0 | 3 | 0 | 0 | 0 | 6 |
| Standard 2.2.4 | Evaluation | PA Moderate | 0 | 1 | 1 | 0 | 0 | 3 |
| Standard 2.2.5 | Restraint monitoring and quality review | FA | 0 | 1 | 0 | 0 | 0 | 1 |
| Standard 2.3.1 | Safe seclusion use |   | 0 | 0 | 0 | 0 | 0 | 5 |
| Standard 2.3.2 | Approved seclusion rooms |   | 0 | 0 | 0 | 0 | 0 | 4 |

|  |
| --- |
| Restraint Minimisation and Safe Practice Standards (of 6): N/A: 0 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 1 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 21): CI:0 FA:8 PA:1 UA:0 NA: 0 |

1. Infection Prevention and Control

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Attainment** | **CI** | **FA** | **PA** | **UA** | **NA** | **of** |
| Standard 3.1 | Infection control management | FA | 0 | 3 | 0 | 0 | 0 | 9 |
| Standard 3.2 | Implementing the infection control programme | FA | 0 | 1 | 0 | 0 | 0 | 4 |
| Standard 3.3 | Policies and procedures | FA | 0 | 1 | 0 | 0 | 0 | 3 |
| Standard 3.4 | Education | FA | 0 | 2 | 0 | 0 | 0 | 5 |
| Standard 3.5 | Surveillance | FA | 0 | 2 | 0 | 0 | 0 | 8 |
| Standard 3.6 | Antimicrobial usage |   | 0 | 0 | 0 | 0 | 0 | 5 |

|  |
| --- |
| Infection Prevention and Control Standards (of 5): N/A: 0 CI:0 FA: 5 PA Neg: 0 PA Low: 0 PA Mod: 0 PA High: 0 PA Crit: 0 UA Neg: 0 UA Low: 0 UA Mod: 0 UA High: 0 UA Crit: 0Criteria (of 29): CI:0 FA:9 PA:0 UA:0 NA: 0 |

|  |
| --- |
| **Total Standards (of 50) N/A:** 0 **CI:** 0 **FA:** 42 **PA Neg:** 0 **PA Low:** 5 **PA Mod:** 3 **PA High:** 0 **PA Crit:** 0 **UA Neg:** 0 **UA Low:** 0 **UA Mod:** 0 **UA High:** 0 **UA Crit:** 0**Total Criteria (of 219) CI:** 0 **FA:** 93 **PA:** 8 **UA:** 0 **N/A:** 0 |

# Corrective Action Requests (CAR) Report

Provider Name: Metlifecare Coastal Villas Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:20-Aug-13 End Date: 21-Aug-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXX

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Std** | **Criteria** | **Rating** | **Evidence** | **Timeframe** |
| 1.3.3 | 1.3.3.4 | PALow | **Finding:**There is evidence of a lack of co-ordination in some clinical areas. The instructions of the wound care nurse specialist are documented on a short term care plan and not a wound care management plan. No clear guidelines for ongoing management or regular updated assessment findings are documented.**Action:**Ensure all services are co-ordinated in a manner that promotes continuity of care in all areas (eg, wound care).  | six months |
| 1.3.5 | 1.3.5.2 | PAModerate | **Finding:**Four of ten resident files identify risk factors with no documented interventions to manage the risk.**Action:**Ensure all care plans describe all required interventions to achieve safe outcomes for residents with identified risks. | three months |
| 1.3.6 | 1.3.6.1 | PALow | **Finding:**Not all assessment findings are congruent with interventions shown on care plans. (Also refer comment 1.3.3.4 and 1.3.5.2).**Action:**Ensure interventions are congruent with assessment findings. | six months |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.3.8 | 1.3.8.3 | PAModerate | **Finding:**Where progress is different from expected the service does not always initiate changes. Examples include restraint, pressure area cares, skin tears and wound care, refer criteria 2.2.2.1, 1.3.3.4, 1.3.5.2 and 1.3.6.1.**Action:**Ensure progress is documented and changes initiated and documented when progress is different from expected. | three months |
| 1.3.12 | 1.3.12.1 | PALow | **Finding:**As observed medication in medication packs are not checked against the prescription for accuracy, prior to being administered.**Action:**Ensure all aspects of safe medicine management are undertaken by staff. | six months |
| 1.3.13 | 1.3.13.5 | PALow | **Finding:**Fridges located in the residents' dining room do not have the required daily temperature checks. Food and fluids in the residents' dining room fridge is not covered or dated.**Action:**Ensure all aspects of food safety is managed in all required areas. | six months |
| 1.4.2 | 1.4.2.1 | PALow | **Finding:**Electrical equipment checks are overdue. **Action:**Ensure all electrical equipment checks are undertaken to comply with legislative requirements.  | Six months |
| 2.2.4 | 2.2.4.1 | PAModerate | **Finding:**Restraint is used for safety reasons and one resident who has multiply falls with recurrent injuries whilst restraint is in use, the evaluation review does not identify if the desired outcome to keep the resident safe was achieved. Falls are not acknowledged. Refer to comments in 1.3.8.3. and 2.2.2.1**Action:**Ensure restraint evaluation meets all requirements of this criterion including the identification to show that desired outcome is or is not achieved.  | Three months |

# Continuous Improvement (CI) Report

Provider Name: Metlifecare Coastal Villas Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:20-Aug-13 End Date: 21-Aug-13

DAA: The DAA Group Limited

Lead Auditor: XXXXXXX

**1. 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 1.1.1 Consumer Rights During Service Delivery**

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Staff receive education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) at orientation and as part of the annual education programme (records sighted). Four of four caregivers interviewed, plus one enrolled nurse (EN) confirm they implement the Code into their everyday practice, by encouraging residents' independence, affording them privacy when cares are given and ensuring cultural and spiritual needs are met. The staff also have a clear understanding of the complaints and advocacy process and informed consent.

The ARC requirements are met.

**Criterion 1.1.1.1 Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.2 Consumer Rights During Service Delivery**

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Policy is in place to guide staff actions to ensure residents' rights are discussed and available to residents and family/whanau.

Information on the HDC Code is included in the residents’ admission pack and pamphlets are also available at reception. Every resident’s room has a copy of residents' rights visible for all to see. A poster on residents' rights, written in all languages relevant to this facility is visible at reception. Cards are available in both Maori and English. The residents' admission pack is given either prior to or on admission. There is a video and cassette available for residents who may be visually or hearing impaired.

Pamphlets on the Nationwide Health and Disability Advocacy Service are sighted within the facility and also included in the residents' admission pack. A discussion is held on this at admission as is discussion on the HDC Code, as confirmed by resident and relative interviews.

Admission documentation includes information on the resident's requested advocate, and the contact name and number for this person. This is kept in the resident's integrated record. Metlifecare Coastal Villas has a resident’s advocate who attends the residents' meetings.

Six of six hospital, one of one rest home residents and four of four family members interviewed are aware of residents' rights and how to access information and advocacy support if needed.

The ARC requirements are met.

**Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect**

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Policy states that residents will not be subjected to discrimination, coercion, harassment, sexual, financial, or other exploitation, abuse (physical, psychological, sexual, or financial), or neglect. The Privacy Policy identifies the organisation respects the privacy of consumers at all times.

All bedrooms in the hospital/rest home are single. Residents are able to have their own furniture in their room, with most rooms being fitted out with residents' family photos hanging on the walls and residents' treasures on shelves. All rooms have a large window with a view and an ensuite with a toilet and hand basin. Rooms are well insulated and with the door closed privacy of conversation is maintained. There are 'Please do not enter' signs, that are hung on residents' doors, to prevent people entering when privacy is requested. As observed, staff knock on doors prior to entering residents' rooms.

Separate shower rooms, for residents use, are located in each wing. Toilets and showers have locks and vacant and engaged signs. There is no information of a private nature viewed in public areas.

The organisation has a cultural and spiritual policy in place. This documents that residents' cultural and spiritual needs will be assessed on admission and consultation will occur with the family and the resident. This information is then transferred into the residents' care plans, as sighted in one of one rest home and nine of nine hospital files reviewed.

The policy also includes that staff will have a working knowledge of Maori values provided through education. The contact details for the interpreting service and for Maori leaders is also included in the document.

The resident's preferred name is included on the front page in the resident's file and on the resident's door label. One of one rest home and six of six hospital residents interviewed confirm that staff address them by the name that they prefer and they speak to them in a respectful manner. Staff were heard to use residents' preferred names and respond to residents in a respectful manner on the days of the audit.

Metlifecare Coastal Villas has an abuse and neglect policy in place. Information for staff regarding abuse and neglect of residents is included in orientation of new staff and in the ongoing yearly education programme. The organisation's Code of Conduct identifies company policy on abuse and neglect. The Code of Conduct forms part of the employment agreement. Four of four care givers and one of one enrolled nurse interviewed can verify knowledge of policy in relation to abuse and neglect. Staff received training on abuse and neglect in June 2013 (training records were sighted).

The ARC requirements are met.

**Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.4 Recognition Of Māori Values And Beliefs**

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Policy states the organisation will ensure that the cultural values and beliefs of residents, their whanau and staff are respected, recognising the Treaty of Waitangi in our day-to-day practices.

Metlifecare Coastal Villas has an implemented cultural and spiritual policy. The organisation also has guidelines in place for the development of a Maori health plan. There were no Maori residents in the facility at the time of the audit. The organisation has links with a kaumatua who provides advice on cultural practices. There are policies and procedures in place which identify clearly barriers to care for Maori residents.

Metlifecare Coastal Villa's cultural and spiritual policy documents that staff receive cultural safety training annually that includes Maori values, beliefs and cultural practices. Training records sighted provide evidence of cultural safety training provided in July 2013 and this is confirmed by interview with four of four care givers.

There are policies in place to ensure cultural care plans are documented on admission for Maori residents. These are developed in conjunction with the whanau, the resident and the kaumatua if appropriate.

The ARC requirements are met.

**Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.6 Recognition And Respect Of The Individual's Culture, Values, And Beliefs**

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Metlifecare policy recognises that every individual is inherently influenced by the cultural environment with which they relate and that influence remains with the individual despite a change of living environment. 'We will ensure all cultures values and beliefs of residents are recognised by ensuring that everyone is treated as an individual and provided the support required to practice the beliefs that they have identified as important to them. Cultural values and beliefs will be actively recognised and integrated into daily life for the resident by reflecting in the lifestyle plans and ensuring that we support relationships between consumers, their families and the community. This is evidenced in our lifestyle plans by developing effective relationships to support active participation. All residents have a right to follow their individual beliefs and faith and to receive services in a manner that recognises their individual values and beliefs.'

Residents' cultural values and beliefs are assessed on admission and transferred to their plan of care. Evidence of this is seen in one of one rest home and nine of nine hospital lifestyle plans reviewed. Four of four caregivers interviewed confirm that residents' cultural and spiritual needs are attended to. Residents and their families are included in all assessment and care review processes. This commences at the first assessment on admission. Four of four relatives, one of one rest home and six of six hospital residents interviewed confirm that they are included in all care planning and that they are invited to care reviews. There are informed of any changes and kept up to date with what is occurring.

The ARC requirements are met.

**Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.7 Discrimination**

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Policy states that intimacy and sexuality are managed in a manner that ensures that the rights of the individual are protected and intervention only occurs to ensure balance between the personal rights of the individual and others living and working in the facility.

Staff job descriptions and conditions of the collective agreement, document discrimination and harassment along with the associated disciplinary actions. The staff standards of conduct and job descriptions include guidelines on professional conduct and professional boundaries.

Four of four caregivers can identify resident’s rights to be free from discrimination, harassment and exploitation and their responsibilities as care givers to maintain professional boundaries. One of one rest home, six of six hospital residents and four of four relatives felt safe from exposure to discrimination, harassment or exploitation.

The ARC requirements are met.

**Criterion 1.1.7.3 Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.8 Good Practice**

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🗷 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Policies sighted are up to date. All practising certificates are sighted for staff requiring them - (eg, RNs, EN, podiatrist, pharmacist, medical practitioner and the physiotherapist). Registered nurses are assessed for their competency to administer medications yearly. Competencies are sighted and up to date. Registered nurses have attended recent seminars on infection prevention and control, wound care and syringe driver management. Two RNs have completed the interRAI training. RN and EN skin integrity competencies are sighted.

Of the 28 caregiving staff, ten have completed the National Certificate in Care of the Older Person, with three of those also having completed the dementia papers. The remaining caregivers are being supported to undertake the National Certificate in Care of the Older Person. There is an onsite assessor for the programme at Coastal Villas. Twenty one of the 28 staff have completed first aid courses, with a trained 'first aider' on site at all times. Senior caregivers have an assessment for competency to 'check' the RNs dispensing of controlled drugs. An enrolled nurse, working in the Village, has been assessed as competent to administer insulin, if required.

Staff have access to the internet for best practice information. Metlifecare has a clinical management team that reviews policy and procedures. This team has access to clinical experts (eg, Medlab South, wound care specialists, psycho-geriatrician, the hospice and palliative care team, specialist services at Capital Coast District Health Board (CCDHB) and Lower Hutt District Health Board).

Every month there is a multidisciplinary meeting, between the Manager, senior RN, doctor, the local nurse practitioner, allied health professionals and every second month the psycho-geriatrician, to discuss any resident concerns and interventions required. Family are able to attend if they wish, though most are informed by phone of any changes or plans.

Metlifecare has an orientation and education plan in place for all staff. The annual education programme includes specialist educators, such as infection control specialist and wound care specialist.

The ARC requirements are met.

**Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.9 Communication**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Policies and procedures identify and have a common theme which includes all consumers’ rights to full and frank information as per the Open Disclosure Policy.

The Nurse Manager has an open door policy and residents and relatives can discuss anything with her at any time. Relatives are called immediately an untoward event occurs. This was confirmed at interviews with four relatives and four of four caregivers, and evidenced by family communication records. An in-service education session on open disclosure was held in June-2013 (staff training records sighted). The podiatrist, when interviewed, expressed a communication concern in regards to her documentation, on the podiatry record form, not being read by RNs and potential concerns not being followed up. This was addressed at audit, with the podiatrist now to document concerns on the short term care plan and report to the RN.

Every morning caregivers are allocated a group of residents they are responsible for. This allocation generally stays the same for a week. A RN oversees the care being given to the residents by the care staff. The RN guides the care provided, implements changes as needed and addresses the more complex issues requiring RN expertise. The RN liaises with the resident's doctor over any medical concerns. The facility doctor, who cares for most of the residents, visits every Thursday. Residents' notes are written in every morning and afternoon duty, by the caregiver looking after that resident. Only matters of concern are reported overnight. At every duty changeover there is a verbal handover of residents being cared for. A communication book alerts staff to daily areas to be addressed.

Interpreter services are accessed through Capital Coast District Health Board.

The ARC requirements are met.

**Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The organisation has specific advanced directive documentation which identifies resident and/or family/whanau involvement in this process. This includes advanced directives related to residents' resuscitation wishes. Metlifecare's informed consent policy outlines recording requirements and the information to be provided. This includes an explanation of the informed consent process on admission by the admitting registered nurse.

Written consent is obtained via the admission agreement, for the taking of photographs for identification purposes, providing care and services, outings, residents' name appearing outside their room, for sharing of health information and for the review of care services. Verbal consent is obtained, as observed at audit, on a day to day basis, to carry out the care needed. The admission agreement and consent, acknowledges the process to be followed should Metlifecare be unable to provide the care required for the resident.

Valid advanced directives are in place and guide treatment plans as requested by the resident.

Staff receive education on informed consent and the HDC Code of Rights - training records are sighted. Four of four care givers interviewed can identify the meaning of informed consent. Signed admission forms for general consent are sighted in one of one rest home and nine of nine hospital records audited.

The ARC requirements are met.

**Criterion 1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.11 Advocacy And Support**

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Policy identifies that advocacy services are an essential provision allowing residents appropriate access to independent advice and support. In accordance with our cultural responsiveness policies, all residents receiving services will have prompt access to a culturally and spiritually appropriate advocate whenever required. Advocacy information will be made available for residents (and potential residents) and will be displayed throughout the village.

Information on the Nationwide Health and Disability Advocacy Service is included in the residents' admission pack, with brochures on display and accessible at reception. The registered nurse discusses this service and the residents' right to have a support person on admission with both the resident and family.

Staff receive education on the Nationwide Health and Disability Advocacy Service at orientation and through the ongoing education programme. Four of four caregivers interviewed confirm they understand about the Advocacy Service. They also said that they would act as advocates for the resident if a situation arose, where this was appropriate.

One of one rest home and six of six hospital residents and four of four relatives interviewed confirm they understand about their right to have an advocate as support if they require one; that Metlifecare has a village resident who is willing to act as an advocate if needed; and the Nationwide Advocacy Service is available to them if they wish.

The ARC requirements are met.

**Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources**

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Metlifecare Coastal Villas has an open visiting policy and residents are able to have visitors of their choice. Residents can access services in the community through the activities programme or through individual contacts. Families spoken to report that they are included, as much as possible, and kept informed by staff about their relative’s progress. Four of four relatives, one of one rest home and nine of nine hospital residents interviewed confirm that they can visit or have visitors at any time.

Residents can access services in the community and staff help them do this (eg, Capital and Coast DHB care co-ordinator is based at Paraparaumu). Staff can contact the palliative care team and the hospice at Paraparaumu for advice and support. Residents can access services in the community through the activities programme or through individual contacts. Four of four relatives, one of one rest home resident and six of six hospital residents confirm they go out on outings, have groups come in to visit, can freely come and go with family members as they feel able.

The ARC requirements are met.

**Criterion 1.1.12.1 Consumers have access to visitors of their choice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.1.13 Complaints Management**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🗷 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: The complaints process sighted identifies the required procedure. Complaints will be dealt with in a professional manner by Metlifecare with consideration to any cultural or other values. Complaints should be actively managed in a timely manner and in accordance with Metlifecare’s Complaint Management Policy, and/or any other statutory requirements relevant to the specific situation.

Stage two: Complaints management information is included in resident admission packs and is discussed as part of the admission process. Complaints forms are on display at the front entrance and available from the reception area. Interviews with seven clinical staff (two RNs, one EN, and four caregivers), four of four hospital level family/whanau members and seven of seven residents (six hospital and one rest home level) confirm their understanding of the complaints process. This is confirmed by the results of the resident satisfaction survey results for 2012 which gained a 96% overall satisfaction rating related to complaints understanding and management.

The complaints register identifies that there are three outstanding complaints. One complaint received has been investigated by the District Health Board and relates to activities. This is being well managed by the facility and the activities coordinator is being mentored by a registered diversional therapist on a weekly basis to improve her time management. There were no negative comments received on the days of audit related to complaints.

Two newly received complaints (August 2013) have been acknowledged to the complainant in writing and follow-up is being completed by the nurse manager. One relates to a resident who passed away over two years ago and a copy of the resident's clinical notes have been given to family/whanau as requested. The second complaint is related to the time taken to respond to a call bell. One the day of audit the call bell time for staff to respond to the call bell electronic record was printed and it identifies it took the staff three minutes to respond. The nurse manager will show a copy of the print out to the resident's family/whanau member who made the complaint.

The nurse manager has a very well documented process including corrective actions to show how all complaints have been investigated and managed to date. Documentation identifies that all complaints are registered electronically in Amrisk, and monitored by the Clinical Service Quality and Risk Manager (CSQRM) at the head office.

Staff meeting minutes confirm that complaints are discussed at all staff levels. The CSQRM confirms there have been no Coroner's inquests or police investigations since the previous audit.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🗷 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: Policy states that the Board of Metlifecare is responsible for the Governance of the Company on behalf of shareholders. The Board delegates to the Chief Executive Officer and the Executive Managers the responsibility for the management of the Company. Management provides the Board with regular reports and summaries of the key management parameters including such matters as financial performance, risks and risk management, statutory and legislative compliance. The purpose, scope, direction and goals of the organisation are clearly defined in the business plan which is reviewed annually.

Stage two: Metlifecare Coastal Villas have a specific business plan which is clearly linked to the organisation's business plan. The business plan is reviewed annually and this was undertaken in June 2013. Quarterly quality reviews of how each goal is being met is documented to show achievement to date.

The nurse manager is a RN who has a current practising certificate and has many years experience in aged care. She has the authority, accountability and responsibility for the provision of service shown in her job description. Her education and training ensures her knowledge and skills are maintained related to her role. She has a direct reporting line to the village manager who has been in her role for many years and is very experienced in aged care and also holds a current nursing annual practising certificate. The nurse manager is a member of the local clinical governance group in Paraparaumu area and attends DHB planning and funding meetings on a three monthly basis.

Interviews with four of four family/whanau members and seven of seven residents (six hospital and one rest home) confirm they are satisfied with the services provided and that their needs are met. This is supported by the resident satisfaction survey results sighted for 2012 which gained a 93.6% overall satisfaction rating.

**Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.2 Service Management**

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Stage two: During a temporary absence of the nurse manager the senior RN, who has worked at the facility for many years, manages the clinical processes and the village manager undertakes the management role. The senior RN is expected to run the direct care services on the floor and issues such as complaints are dealt with by the village manager. Support staff from head office assist as required.

**Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: The Quality Management Policy identifies the systems, processes, products and services used by the organisation to ensure appropriate levels of quality are achieved. The procedures undertaken to ensure the Quality Management Policy is shown as:

1. The Annual Operating Plan for the Company will include quality objectives.

2. Quality measurement initiatives (audit process) will be planned and undertaken and outputs from these measurements will be used to ensure continuous quality improvement of services and products.

3. Each Functional Unit (site) annual Business Plan will include Company-Wide quality initiatives as well as Business Unit specific quality initiatives.

4. The outputs from the Company-Wide or Functional Unit specific quality measurement initiatives will be circulated within the Company and shall be used to review, assess and improve the services and products provided to residents.

A risk management planning and reporting document is sighted. This highlights when, to whom and the frequency of reporting of risks are to be undertaken at each level of the organisation. For example a critical risk is reported to the Board, the CEO, General Manager and Manager on a weekly basis whilst a low risk is reported on monthly at management level. Policy states that risk monitoring is to be on-going with a formal review of all risks on a quarterly basis to coincide with normal Business Plan review. Risk Management Schedule is to be reviewed monthly and reported as part of the monthly management reports. Actual and potential risks are identified using a risk consequence form which is rated from one to five. A rating of one is catastrophic and five is insignificant risk. Risks are developed on an assessment sheet which shows likelihood of the risk occurrence ranging from almost certain (one) to rare (five). Reporting frequency and the level within the organisation the risk is reported at is determined by the levels shown using the before mentioned formulas.

The organisation develops and requires each site to implement policies and procedures that are aligned with current good practice and service delivery that meet the requirements of legislation and are reviewed at a minimum of two yearly.

All meetings have a set agenda to ensure quality issues are discussed which include key performance topics such as health and safety, accident and incidents, hazards, infection control, complaints, restraint, quality improvements, training, maintenance and audit outcomes. Quality improvements are to be identified using an organisational form.

Stage two: Metlifecare Coastal Villas implements quality and risk management systems to comply with organisational policy. Interviews with 14 of 14 staff confirm their understanding and input into quality systems. Staff and meeting minutes sighted confirm they are informed when audits identify an issue that requires a corrective action. One example relates to improving communication between management and registered nurses. Evidence of weekly meetings is documented and includes discussions related to multidisciplinary meetings, care plan updates, care plan evaluations, incident and accident reporting, medication and GP visits.

The nurse manager ensures all policies are current. Obsolete policies are filed electronically at organisational level.

Staff meeting minutes identify that key components of service delivery are a standing agenda item. Information is linked to organisational quality management systems and recorded via Amrisk. Information is then benchmarked against other Metlifecare facilities and printed in the 'MET bulletin' which is available to staff, residents and family/whanau. If the benchmarking comparisons are outside the organisation's required norms, the CSQRM contacts the nurse manager and monthly reports must identify what corrective actions are being undertaken to improve any given situation until the matter is resolved. (All trended data is reporting using 1000 occupied bed days).

Quality improvement data is collected via audits, complaints follow up, resident satisfaction surveys, and results from regular data collection for infection control, health and safety (which covers accidents and incidents), and hazard management. When a corrective action or quality improvement is raised at a meeting, a staff member is delegated to take responsibility to undertake the improvement required and to report back to the following months meeting. The nurse manager keeps a documented record of corrective action outcomes. There are corrective actions related to wound care on incident and accident forms and these are being followed up by management.

Monthly resident meetings (which family/whanau are welcome to attend) and annual family/whanau meetings are used to keep residents and family/whanau informed of any new risks or issues as appropriate. This is confirmed in six of six hospital and one of one rest home level care resident file reviews and during resident and family/whanau interviews.

Risks and potential risks (including clinical risks) to residents, staff and visitors are actively managed and monitored by the health and safety committee. This is confirmed in meeting minutes sighted. Risks are identified in a risk register and corrective action planning is monitored at facility and organisational level. The risk register shows the measures put in place to eliminate, isolate or minimise all risks are appropriate to the services provided. One example relates to the fish tank moving in a recent earthquake. The fish tank has been moved to a safer area by a contacted company. New staff are required to sign to say they have read and understand the risks shown in the risk register as part of the orientation process as confirmed in staff file reviews and during staff interviews. The hazard register is kept in the nurses’ station for easy access for all staff. Health and safety including any newly identified risks are a standing agenda item on staff meeting minutes.

**Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.**

 This shall include, but is not limited to:

 (a) Event reporting;

 (b) Complaints management;

 (c) Infection control;

 (d) Health and safety;

 (e) Restraint minimisation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: The Open Disclosure policy identifies that residents and their family/whanau have the right to know what has happened to them and to be kept fully informed.

Stage two: One area identified for improvement in the previous audit is now fully attained. As confirmed during interview with the nurse manager and the village manager, they have a good understanding of the correct authority notification in the event of serious harm, infection outbreaks or sudden death. There are specific organisational forms for reporting adverse events. Two notifications sighted relate to one resident who sustained a fractured femur and a resident who sustained a foot fracture. Notifications were sent to the Ministry of Business Innovation and Employment. No follow up actions were required.

Metlifecare Coastal Villas ensure adverse events are recorded on incident and accident forms and that the information is used to improve services when required. Incidents and accidents are entered into Amrisk and data is benchmarked against other Metlifecare facilities.

A review of seven of seven resident files (six hospital and one rest home) and two files reviewed for restraint and incident and accident reporting only confirm incident and accident forms are completed to show corrective actions are taken as appropriate. Incident and accident events are discussed at monthly staff and management meetings as confirmed in minutes sighted. Family/whanau reporting is clearly documented on a specific form in all file reviews.

Interviews with staff, residents and family/whanau confirm adverse events are discussed in an open and honest manner.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: Policy states that the Company supports and facilitates training and education that is appropriate to the needs of the organisation, and maintains records of this training. All sites will facilitate training in line with the identified core needs of the business. All training and education must be recorded on the appropriate documentation. Training needs will also be identified in the annual performance appraisal process.

• Core training will be identified and provided for all staff as per the core training schedules. Core training schedules will identify both essential (all employees in a particular employee group must attend this training) and preferred (all employees is an employee group are encouraged to attend this training).

• The Company facilitates the Aged Care Education (ACE) Core Programme (provided by Health Ed Trust) as part of the development of the care giving staff.

The Recruitment policy states: Managers will employ the best possible and most appropriate person for each vacancy without discrimination and will comply with Metlifecare procedures while doing so. Job descriptions sighted for activities co-ordinator levels one and two; caregivers levels one, two and three; cook; diversional therapist; domestic aid (cleaning and laundry); handyperson; kitchen hand; kitchen manager; maintenance worker; nurse manager; registered nurse levels one and two and senior registered nurse. They all show key results, key tasks/accountabilities and performance objective measures.

The Orientation policy states: All new staff will be supported to assist them to integrate into their new work environment and role. Metlifecare will provide the necessary training and support to enable new employees to perform the functions of their role to the standard that the Company requires.

All newly employed staff will receive a comprehensive orientation to enable them to successfully achieve the responsibilities and objectives of their role, and to enable them to function effectively and safely as a team member. There is a checklist in place that is required to be completed to identify staff orientation has been completed and reviewed after three months service and then annual reviews are to follow.

Stage two: The validation of professional qualifications is maintained by the nurse manager and current annual practising certificates are sighted for one GP, one physiotherapist, one podiatrist, one pharmacist, ten registered nurses (one is the nurse manager and one is the village manager) and one enrolled nurse. There are 21 staff who hold current first aid certificates.

Interviews with seven of seven residents (six hospital and one rest home) and four of four family/whanau members confirm that services are delivered in a manner to meet all their needs, wants and likes.

A review of eight of eight staff files (the nurse manager, one senior and one junior RN, the activities coordinator, one cleaner one laundry worker and two caregivers (one newly employed and one who works night duty), show that all organisational orientation processes are implemented by the service. Staff interviews with 14 of 14 staff from across all services confirms the orientation offered allows them to undertake the role they are employed to do. (One staff member asked to see the auditors related to orientation but the meeting did not occur as the staff member did not come to see the auditors even though they had an open invitation to do so). There is documented evidence that one caregiver was given an extra weeks orientation owing to needing further training to undertake the role in a timely manner. Annual appraisals sighted are up to date. Human resources management processes implemented meet legislative requirements and are reflective of current good practice.

The service has a system in place to identify, plan, facilitate and record education. Staff education is appropriate to the age care sector and documented for each individual staff member. Education is evaluated and this information is used to improve content and what is being offered to ensure it is relevant to staff and the current services being offered. Caregiver records identify that with the exception of two recently employed staff, all caregivers have either completed or are in the process of completing Aged Care Education (ACE) standards including dementia care. The activities coordinator has completed ACE advanced and is currently commencing diversional therapy papers.

**Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.8 Service Provider Availability**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: There is a process at organisational level to determine safe staffing levels at all facilities.

Stage two: A review of six weeks of rosters confirm staffing levels and skill mix is implemented by Metlifecare Coastal Villas to meet policy requirements. Staff replacements for sickness and/or annual leave are shown on the rosters sighted. All shifts are covered by a staff member who holds a current first aid certificate and a registered nurse. Documentation confirms there are 21 staff who hold current first aid certificates. The nurse manager ensures that there is a mix of senior and junior staff on all shifts.

Staff interviews with 14 of 14 staff from across all services, confirms 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. The nurse manager and clinical quality and risk manager confirm that rostered staff numbers are adjusted to meet resident acuity levels. Resident and family/whanau interviews confirm they have no issues with staffing numbers.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.2.9 Consumer Information Management Systems**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: The organisation uses a specific admission information form to ensure accurate and timely information is available related to all residents. Archiving policy identifies how legislative requirements are to be met by the organisation. The Guideline to Documentation policy identifies that staff are required to write legibly and sign using their full name and designation when making an entry into resident notes.

Stage two: As observed, resident information is stored and filed to ensure it is not on public display. The archived records for the facility are securely stored on site. Files are retrievable as required. The service is undertaking a review of archived files to ensure the process used keeps all resident records together. Administrative information is entered into the resident's file upon entry as confirmed in the seven of seven resident file reviews. All resident files are integrated.

The seven of seven residents' files reviewed identify entries are legible and show the date, time and name and designation of the provider entering the information.

**Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

am pm and night if relevant or if there is an issue

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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 1.3.1 Entry To Services**

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Policy identifies entry processes which are communicated to residents, family/whanau and referral agencies. Residents are assessed by Needs Assessment and Service Co-ordination (NASC) agency to ensure they are appropriate for hospital or rest home level of care. There are seven swing beds that can be accessed by residents with a NASC assessment at a rest home level of care. Information related to the service offered is available in brochures and on the Metlifecare and Eldernet websites. The service operates twenty four hours a day and seven days a week.

If people make enquiries and they have not been assessed they are advised to discuss entry processes with their general practitioner (GP) or the local NASC agency. All enquiries are documented on the facility enquiry form.

The ARC requirements are met.

**Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.2 Declining Referral/Entry To Services**

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Policy describes processes undertaken should entry to service be declined. This includes notification to appropriate persons and agencies. All enquiries are documented on a specific enquiry form which is kept on file. The only reason a person would be declined entry is if a bed is unavailable for the required level of care. NASC are kept informed of bed availability and the Eldernet website is updated daily. NASC are informed as required if a resident is declined entry as appropriate.

If someone makes an application for entry who is not assessed as being suitable for the level of care provided, they are referred back to their GP or to NASC, who will advise them of other local facilities in the area. Family/whanau are informed as appropriate. This process is documented on the enquiry form.

The ARC requirements are met.

**Criterion 1.3.2.2 When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.3 Service Provision Requirements**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Low

The development of a Lifestyle Plan is to be a transparent partnership process. Metlifecare staff must work collaboratively with the resident and the resident’s family, advocate or other healthcare providers to complete the comprehensive lifestyle plan. Lifestyle Plans must be developed within 24 hours of admission. The full Lifestyle Plan is developed within three weeks of admission. The plans are evaluated when needs change and no less than once each 3-6 month period. Evaluation includes consultation with the resident, the multidisciplinary team, resident family and or advocate.

There is a specific handover sheet used describing each resident and their needs on a per shift basis.

Residents receive timely, competent and appropriate service delivery from staff who receive training appropriate to their role. Staffing is appropriate to the level of care provided to ensure the needs of residents are met.

Admission is generally planned at a time that allows a RN plenty of time to attend to the admission process. The admission agreement identifies the process to be followed, if the service is unable to provide the services the resident requires. All residents are admitted by the RN who undertakes a comprehensive assessment of the resident’s needs. This assessment is, if appropriate, done in consultation with the resident and their family / whanau. An initial care plan is developed within 24 hours of admission with a lifestyle care plan developed within three weeks. Ongoing assessments, review and evaluation of lifestyle plans is conducted three monthly or as residents need changes, by registered nurses.

An initial medical review occurs within 24 hours of admission, if the resident has not been seen by a doctor within two days prior to admission. On-going medical review occurs monthly, unless the GP deems the resident stable and able to be reviewed three monthly. Medicine review occurs three monthly unless there is a need to review more frequently

Practising certificate are sighted for all staff who require them. Caregivers employed have completed or are in the process of completing their Aged Care Education (ACE) programme in support of the older person.

Residents have one set of clinical notes which is written in by all providers. Clinical staff, diversional therapists, physiotherapists, medical staff and visiting specialists all write in the same set of notes.

There are verbal 'handovers' between shifts where information related to residents is shared. The nurses and caregivers use a communication book to ensure all appropriate changes to residents' care needs, activities of daily living, and changes to equipment is notified. As confirmed by four of four clinical staff interviewed, they use the information given at handover, residents' lifestyle plan information and the communication book to ensure they are aware of any changes required to a resident's care.

Tracer 1: A hospital resident

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

Tracer 2. A rest home resident,

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

 The ARC requirements are unmet.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

There is evidence of a lack of co-ordination in some clinical areas. The instructions of the wound care nurse specialist are documented on a short term care plan and not a wound care management plan. No clear guidelines for ongoing management or regular updated assessment findings are documented. A resident with a chronic wound has no plan that clearly directs how this is to be managed.

**Finding Statement**

There is evidence of a lack of co-ordination in some clinical areas. The instructions of the wound care nurse specialist are documented on a short term care plan and not a wound care management plan. No clear guidelines for ongoing management or regular updated assessment findings are documented.

**Corrective Action Required:**

Ensure all services are co-ordinated in a manner that promotes continuity of care in all areas (eg, wound care).

**Timeframe:**

six months

**STANDARD 1.3.4 Assessment**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Assessments are sighted for challenging behaviour (refer 1.3.6), dietary requirements, falls, neurological observations, pain, skin management and wound assessment and treatment tool.

Residents' needs and requirements are identified through an appropriate assessment process, other service providers, residents and family/whanau. The information gathered is used to inform the care planning process to ensure the services put in place meet all the resident's needs. Information related to care provision and requirements are shared with residents and family/whanau as per open disclosure principles.

Initial assessments are informed from NASC assessments, information and records from the resident’s GP, the place of transfer, any other health care providers involved in the resident's care and the resident and family/whanau as appropriate. The initial care planning is undertaken within 24 hours on an initial care plan and covers; personal cleaning and dressing, elimination, eating and drinking, mobilisation plus a falls risk assessment, sleeping, Water low pressure area care, communication, social behaviour, cultural needs, spiritual needs, controlling pain, breathing, social needs, sexuality, grieving and dying and dependency level.

Prior to admission or within two days of entry the GP undertakes a full medical assessment which is documented in the resident's progress notes. Blood pressure and weight is routinely recorded on admission and monitored monthly or more frequently as required.

Long term lifestyle plans are developed within three weeks of admission, from ongoing more comprehensive assessments undertaken by the RN. As required in Metlifecare policy the Water low pressure area care assessment, activities plan, falls risk, continence and any other resident required assessment are updated three monthly. A medical review is undertaken monthly or three monthly if the resident is deemed medically stable. A full evaluation of all other assessments and care planning is undertaken three monthly. Multidisciplinary reviews are carried out monthly, with the psycho-geriatrician in attendance two monthly. Any residents causing concern are discussed at these meetings.

If the resident's condition changes updates occur as required. The resident, family/whanau and other relevant health care providers are included and informed of all updates as evidenced in one of one rest home and nine of nine hospital records and confirmed by four of four family members and six of six hospital and one of one rest home residents interviewed.

The ARC requirements are met.

**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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.5 Planning**

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Moderate

Residents' clinical notes are integrated and resident focused, to ensure service delivery reflects continuity of care. Care planning through the lifestyle plan, reflects input from all providers involved in residents' care. One of one rest home and nine of nine hospital care plans reviewed on the days of audit, reflect the individual resident’s needs, however four of the ten care plans reviewed do not describe the required support and interventions for residents to achieve the best possible outcomes.

One resident's file, that identified a resident with a pressure area, has a wound care management plan, with minimal detail on how the wound is to be managed, that recorded the wound as deteriorating and not healing at the last dressing change (8 days prior). No change or review in management is documented. Wound was reviewed by the hospital Manager at audit. Wound sighted to be superficial and not be deteriorating.

Three of three files identify residents at high risk of falls. No plan is documented to guide the process needed to minimise each individual's risk of falls.

A full evaluation of all cares is undertaken three monthly. Changes to resident's needs are documented in long term lifestyle plans and short term care plans as appropriate. Seven of seven clinical staff interviewed confirm they are made aware of any changes to residents' cares during handover, and in the communication book. Residents and family/whanau are involved in all aspects of care planning as appropriate.

The ARC requirements are unmet.

**Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

Four of ten files identify residents at high risk of falls, a resident displaying challenging behaviour (refer 1.3.6) and a resident with a pressure area. No clear plan is documented to guide the process needed to minimise or manage each individual's risk.

**Finding Statement**

Four of ten resident files identify risk factors with no documented interventions to manage the risk.

**Corrective Action Required:**

Ensure all care plans describe all required interventions to achieve safe outcomes for residents with identified risks.

**Timeframe:**

three months

**Criterion 1.3.5.3 Service delivery plans demonstrate service integration.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.6 Service Delivery/Interventions**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🗷 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

Service provision is guided by Metlifecare organisational policies and procedures, which reflect current accepted good practice standards and meet legislative requirements. The lifestyle plans document the individual resident’s needs, interventions and goals. The lifestyle plans document the resident's, physical, social, spiritual and emotional needs and desired outcomes such as, hygiene, mobility, sleep,

- nutrition

- skin integrity

- communication

- pain management

- culture

- spirituality

- sexuality

- psycho-social

- family support.

One of one rest home and nine of nine hospital files are reviewed. A resident with challenging behaviour, has conflicting management strategies. The care plan described the resident responding best with one to one care. While the RN described behaviour is best managed by two persons. The resident was described by staff interviewed as "difficult" to manage. No documentation was sighted to support psycho-geriatric assessment. (Refer also criteria 1.3.3.4 and 1.3.5.2).

 One of one rest home, nine of nine hospital residents and four or four family interviewed confirm they are very happy with the care and services they receive. Satisfaction surveys verify 97% satisfaction with nursing care, 97% with resident support and 96% with resident involvement.

Interview with one of one GP, who manages the care of many of the hospital residents, verifies satisfaction with the care provided by Metlifecare. He attends every week and is on call 24 hours per day, seven days a week. Staff call him promptly if they have concerns. They carry out his requests promptly and efficiently. Residents and family interviewed verify satisfaction with medical care provided. Satisfaction surveys identified 96% satisfaction with medical services.

There are appropriate links developed with other services, such as, diabetes resources, community mental health teams, nurse specialists, the hospice, Capital & Coast DHB. In the four of the ten residents' files reviewed, referrals sighted include, NASC services, gerontology, wound care specialist and hospice services. All residents and family interviewed confirm they are kept well informed and given choices related to all services provided.

The ARC requirements are unmet.

**Criterion 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.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

A resident with challenging behaviour, has conflicting management strategies. The care plan described the resident responding best with one: management. While an RN described behaviour best managed by two persons. The resident was described by staff interviewed as "difficult" to manage. No documentation is sighted to support psycho-geriatric assessment to assist in guiding behaviour management strategies.

**Finding Statement**

Not all assessment findings are congruent with interventions shown on care plans. (Also refer comment 1.3.3.4 and 1.3.5.2).

**Corrective Action Required:**

Ensure interventions are congruent with assessment findings.

**Timeframe:**

six months

**STANDARD 1.3.7 Planned Activities**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🗷 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Policy is in place related to 'Client Centred Process' for activity planning. Information regarding each resident’s activity needs and choices will be gathered on admission and regularly reviewed thereafter. Relevant information will be shared with members of the multidisciplinary team. Documentation identifies that the diversional therapist or activities co-ordinator will gain an understanding of a resident’s preferred use of time, and formulate an individual activity plan that meets their needs, abilities and preference.

Each resident has an individual assessment undertaken within a few days of admission, after a settling in period, from which their activity plan is developed. Activities are developed to reflect the resident's identified needs and preferences. Residents choose which activities they wish to participate in. Family/whanau and friends are welcome to join in any of the activities offered.

The activities co-ordinator has completed the core competency papers for the National Certificate in Health of the Older person, a pre-requisite for the diversional therapy training, which she is just hoping to commence. She has worked at Metlifecare for eighteen months in the activities co-ordinator role, works Monday to Friday 0900-1500, and is supported in her role by the village activities co-ordinator, management, and a local diversional therapy educator, who guides and oversees the programme four hours a month to ensure it meets residents' needs and is appropriate for the acuity of all residents. The activities co-ordinator is a member of a diversional therapist network in Wellington and she regularly attends their meetings and conferences. The activities assessments sighted in nine of nine hospital residents' files include the residents':

- life history

- favourite things, past, current and future interests

- physical, intellectual, social and cultural needs.

All activities are planned on a monthly basis. Some activities are changed as they are weather dependent, but if this occurs, residents are informed. The activities coordinator reports that over the winter some of the bus outings required to be cancelled due to bad weather. Planning takes into account residents' skills and interests and each of the nine hospital residents' files reviewed have an individual activity plan and daily attendance sheet that is up to date.

The activities co-ordinator in the hospital plans the activities programme in the hospital, while a village programme also operates and some residents attend these activities as and when they or their families desire. The village programme includes a more active programme. Information used to develop the hospital activities programme takes into account all residents' activities assessments. A record is kept of all residents' participation and this is used as a tool to gauge interest. There are monthly resident meetings which are led by the activities co-ordinator. The meetings have a set agenda and cover minutes from the last meeting, welcome to new residents, the activities programme, maintenance issues, introduction of new staff, meals, laundry and general business.

 Nine of nine individual activity and diversional therapy plans sighted for residents match their known skills, likes, dislikes and interests and are updated monthly as required. Activity plans revolve round group and one on one activities. The activities provided are based on the activities co-ordinator 'knowing' the resident and 'knowing' what the resident likes.

A recent complaint made reference to residents being 'pushed into a lounge after breakfast and being left with no activities until lunchtime'. On the two days of audit an activities programme operated from 0900-1500. Four of four care staff, nine of nine hospital residents and four of four relatives verify the programme operates Monday-Friday. The programme includes music, games, activities, church services, movies, quizzes, exercises, beauty sessions, community group visits, theme days, 'high teas' in lavish china from the china cabinet in the lounge, storytellers and outings. Relatives are welcome to participate and four of four relatives interviewed enjoy participating in the programme offered. Nine of nine residents interviewed had differing views with the programme. The more active residents prefer to attend the village programme, or go on frequent outings with families. The residents that did attend the programme, were observed to be actively involved. A resident with alteration in some sensory faculties has a talking book. She enjoys being in her room listening to the book, though at times also enjoys joining in with the activities programme. She reports she has her own supply of batteries should they run out. A resident who's batteries for her radio had run out was observed to ask a caregiver if there was any spare batteries and these were provided to her.

A recent resident satisfaction survey identified 81% satisfaction with activities, with the suggestion that a greater range of activities be offered. This feedback is noted by the activities co-ordinator and the suggestion made to visit other facilities and view the content of their programme.

The ARC requirements are met

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.8 Evaluation**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Moderate

Evaluation of residents' care is undertaken on a daily basis and documented in the progress notes. If any change is noted in the resident's condition it is reported to the RN. Documented changes in progress notes and regular three monthly assessment evaluations are evident in one of one rest home and nine of nine hospital files reviewed.

Five of the nine hospital files reviewed had no documented changes in the lifestyle care plan, wound care or short term care plan when the residents progress is different from expected. One of one resident file, that identified a resident with a pressure area, had a wound care management plan that recorded the wound as deteriorating and not healing at the last dressing change. No change or review in management documented. Wound was reviewed by the hospital Manager at audit. Wound sighted to be superficial and not be deteriorating.

Of the thirty hospital residents, thirteen wound are being attended to, with nine of those being skin tears. Residents with skin tears have no documented evidence in their files that evaluated the reason and possible changes to be made to minimise the risk of receiving skin tears, or how they occurred.

Short term care plans are put in place for residents as required. A resident with a fungal infection has a short term care plan, describing the treatment and recording the infection had resolved.

Medical reviews are undertaken monthly or three monthly if the resident's condition is deemed stable. Medicine review is undertaken three monthly.

Any change in a resident's care is documented in the communication book, in the resident's progress notes and discussed at staff handover as seen on the day of audit.

Family/whanau are kept well informed as confirmed during four family/whanau interviews and sighted on 'family communication’ sheet in one of one rest home and nine of nine residents' notes.

The ARC requirements are unmet.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

One of one residents' file reviewed, that identified a resident with a pressure area, had a wound care management plan that recorded the wound as deteriorating and not healing at the last dressing change. No change or review in management is documented. The wound was reviewed by the hospital manager at audit. The wound sighted to be superficial and not to be deteriorating. Of the thirty hospital residents, thirteen wound are being attended to, with nine of those being skin tears. Residents with skin tears have no documented evidence in their files that evaluated the reason and possible changes to be made to minimise the risk of sustaining further skin tears, or how they occurred. Short term care plans are put in place for residents as required.

**Finding Statement**

Where progress is different from expected the service does not always initiate changes. Examples include restraint, pressure area cares, skin tears and wound care, refer criteria 2.2.2.1, 1.3.3.4, 1.3.5.2 and 1.3.6.1.

**Corrective Action Required:**

Ensure progress is documented and changes initiated and documented when progress is different from expected.

**Timeframe:**

three months

**STANDARD 1.3.9 Referral To Other Health And Disability Services (Internal And External)**

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Residents are supported to access other health and/or disability service providers as required or requested. Referrals sent are documented and followed up appropriately. Family/whanau involvement is well documented on lifestyle care plans, family communication sheets and progress notes, and this is verified by four of four relatives, one of one rest home resident and nine of nine hospital residents.

Residents are given a choice of GP when they are admitted to the facility and they can request a change at any time. If the need for other services are indicated or requested the GP or RN either send a referral to seek specialist service provider assistance, such as, the hospice nurses. The resident and their family/whanau are kept informed of any referral processes. Three of the nine hospital residents' files identified a need for referral to other health and disability services and evidence of referral is sighted. Any referrals sent are followed up accordingly by either the RN or the GP. The GP discusses the referral to be sent with the resident to ensure they understand the reasons for referral; as sighted in documentation of the three residents referred and confirmed during the GP interview. Family/whanau members confirm they are kept well informed related to expected wait times. Where possible, a family member or friend accompanies residents to appointments. The facility has a van and staff that can escort the resident to appointments if required.

The ARC requirements are met.

**Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer**

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The organisation has a specific transfer form to identify any known risks. Exit, discharge or transfer from the service is planned and co-ordinated by staff. The resident and family/whanau are kept fully informed of the during the process as appropriate.

There are organisational policies and procedures implemented by the service to ensure exit, discharge or transfer of residents is undertaken in a safe manner. There is a specific transfer/discharge 'yellow envelope' which accompanies the resident and contains forms that document the needs and requirements of residents during this process. The form highlights any known risks, such as infections, falls risk. Other information sent, includes a list of the resident's current medicines, EPOA forms, resuscitation status, all the resident's current information related to NHI, DOB, next of kin, any instructions related to specific treatment, such as wound care requirements, and may include a doctors referral as appropriate. If the resident has been transferred to the public hospital, and following treatment, is to return to the rest home, the other side of the envelope includes a checklist for the hospital to complete on discharge. If the resident is transferring to another facility or to the public hospital a verbal handover is also given by the RN. Communication is maintained with family/whanau at all times as confirmed during interview.

There is open communication between the service and family/whanau related to all aspects of care including exit, discharge or transfer. The RN interviewed indicates that if there were any specific requests or concerns that the family/whanau or resident wished to discuss, these would be noted on the transfer form.

The ARC requirements are met.

**Criterion 1.3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.12 Medicine Management**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

The organisation has appropriate policies and procedures in place to reflect safe and timely medicine management. Procedures comply with current legislative requirements. Pharmacy reconciliation of each resident's medication chart will be undertaken at least every six months. Staff who administer medicines must be competent to do so. A specific insulin competency is sighted. There is policy in place for residents who wish to self-administer medicines.

A previous corrective action has been attended to - twelve of twelve medication charts reviewed are clearly typed, easy to read and crossed out by the GP when discontinued. Medico packs dispensed from the pharmacy are checked by the RN for accuracy and evidence supports this.

All residents packed medication are stored in resident's individual files, with the resident's medication chart and the signing chart. Non-packed medicines are stored safely and checked as required.

The medicine management policy describes the procedure to be followed when administering medication. However, on the day of audit, an RN observed administering medications, did not check the packed medication against the GP's signed medication request, to ensure the correct medication was being given and this is an area identified for improvement.

The individual resident's photo is present in 12 of 12 medicine files viewed and allergies where identified are highlighted with a bright sticker.

Medicine fridge temperatures are recorded and are within range. All medicines are kept in a secure medicine/treatment room. Unused or expired medicines are returned to the pharmacy for disposal. Eye drops are dated when opened.

Twelve of 12 medicine records reviewed document the GP's three monthly review of the residents' medicines.

Controlled drugs when dispensed are checked by an RN and a senior caregiver deemed competent to check controlled drugs, if another RN is not available. A weekly stock check is sighted as is a six monthly quantitative check by the RN and the pharmacist.

Competency testing is undertaken annually; confirmed in the RN and senior caregiver staff files reviewed.

There is policy in place for the safe self-administration of medicines by residents. Two current residents self-administer their spray medication only. The policy on self-administration includes the criteria for self-administration, resident education, safe storage and assessments by the GP and RN. Evidence of compliance with policy is sighted.

Standing order requests meet current standing order guidelines. Medicine charts have signature verification. The pharmacist is available for assistance and on-going education, as required, and supply information related to residents' medicines, such as, not to be crushed.

The ARC requirements are not met

**Criterion 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.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

A previous corrective action has been attended to with twelve of twelve medication charts reviewed being clearly typed, easy to read and crossed out by the GP when discontinued. Medico packs dispensed from the pharmacy are checked by the RN for accuracy and documented evidence supports this.

The medicine management policy describes the procedure to be followed when administering medication. However, on the day of audit, a RN observed administering medications, did not check the packed medication against the GP's signed medication request, to ensure the correct medication was being given and this is an area identified for improvement.

**Finding Statement**

As observed medication in medication packs are not checked against the prescription for accuracy, prior to being administered.

**Corrective Action Required:**

Ensure all aspects of safe medicine management are undertaken by staff.

**Timeframe:**

six months

**Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

The Food Preparation policy states: All food prepared in the kitchen will be produced in accordance with the menus and recipes provided and under the strictest hygienic conditions to provide food of the highest possible standard and to be free from potential food safety hazards (chemical, physical and or microbiological). All food preparation shall be undertaken within appropriate areas using appropriate staff and equipment. The Waste Management policy identifies that food waste is disposed of via kitchen sink waste disposal or general waste disposal.

Residents' nutritional needs are provided by a contracted food service in which the menu is developed by a registered dietician and approved as meeting the dietary requirements for aged care. Individual food and nutritional needs are identified on a resident's dietary profile and are met by the service. The kitchen is well equipped, clean and tidy. A stock rotation system is in place.

The food service at Metlifecare Coastal Villas is a contracted service from the Compass Group's subsidiary Medirest which specialises in food, service for senior living and healthcare industries. The Medirest Nutrition and Menu Planning checklist incorporates relevant standards and guidelines from the Ministry of Health Food and Nutrition Guidelines for Older Adults and the National heart Foundation Catering Guidelines for Older Adults.

All kitchen staff have level NZQA167 training, with the kitchen manager / trained chef having additional training having completed the 'Diet care senior living and nutritional course' put on by Medirest. There are regular updates of this training every two years. All kitchen staff have two yearly first aid training. The kitchen manager delivers the onsite training to the kitchen staff.

The Coastal Villas kitchen service has obtained the only 100% audit rating for compliance with all policies and procedures of all Medirest's 500 sites. The Kapiti district council have just awarded it an A rating certificate for food safety and hygiene, and verifies all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. Temperature records of fridge, freezers, food and dishwashers are recorded and sighted. Cleaning and rodent management regime in place and sighted. Food in kitchen fridges covered and dated. The kitchen is clean and well equipped. Kitchen staff are dressed appropriately with appropriate personal protective equipment, such as, aprons and hats. Food stocks are rotated to ensure older purchases are used first. The kitchen uses colour coded equipment, such as, preparation boards to ensure there is no cross contamination of raw and cooked foods.

The dietician review in July 2013 indicates that the menus were reviewed in relation to therapeutic diets, meal preparation and menu planning. The dietician review indicates that the 'menu is well planned and notable for its limited use of high fat and high sodium convenience foods'. An upcoming review is to be held to discuss recommendations round enhancing the quality and nutritional value of pureed diets by providing more detail, specify menu accompaniments and to ensure the menu provides a third serving of milk / milk products daily.

Residents with additional or modified nutritional requirements have these identified in their dietary profile which is undertaken by the RN upon admission and updated as required. A copy of the dietary profile is kept in the kitchen and displayed on a white board. The profile identifies residents' additional or modified nutritional requirements, as well as likes and dislikes. The dietary profile records instructions related to what plate to use, if food should be cut up, and the type and size of the meal. Dietary supplements such as Complan are given out by the clinical staff.

One of one rest home, nine of nine hospital residents and four of four family/whanau members interviewed confirm that the food is of a high standard and there is always plenty of it.

Equipment sighted includes modified cutlery, lip plates, straws, various plate sizes and sipper cups. The cook reports that they are able to cater for all residents eating requirements. As seen during meal time, residents' meals are served using appropriate crockery according to their needs.

An area identified requiring improvement relates to the residents' fridges in the residents' dining rooms, where no documentation is sighted of fridge temperature recordings and food in fridges is not covered or dated.

The ARC requirements are not met.

**Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Fridges in residents' dining rooms have no evidence to support fridge temperatures are being checked. Food in the residents' dining room fridges is uncovered and not dated.

**Finding Statement**

Fridges located in the residents' dining room do not have the required daily temperature checks. Food and fluids in the residents' dining room fridge is not covered or dated.

**Corrective Action Required:**

Ensure all aspects of food safety is managed in all required areas.

**Timeframe:**

six months

**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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

**STANDARD 1.4.1 Management Of Waste And Hazardous Substances**

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: The organisation has policy and procedures related to safe an appropriate storage and disposal of all waste substances which complies with current legislation. Approved yellow sharps containers should be used for the disposal of any sharp object which may cause injury, including needles and needle syringe combinations.

Stage two: Staff interviews confirm they follow documented process related to safe and appropriate storage and disposal of waste. Staff have access to personal protective equipment and clothing (PPE) and they understand when PPE is to be worn. Staff are observed using PPE when required. Staff education occurred in June 2013 as part of an infection control in-service related to standard precautions and the use of PPE.

The village manager and nurse manager confirm there are no specific territorial authority requirements related to waste disposal. All cleaning and laundry staff have undertaken safe chemical handling training in June 2012. Yellow bins sighted for the safe disposal of sharps. Emergency planning includes actions to be taken should an incident occur involving infectious substances or chemicals. All chemicals used for cleaning and laundry are safely stored.

A discussion was held on the first day of audit related to kitchen chemicals being made more secure. The chemical bottles were moved and a secure area has been put in place in the kitchen to store chemical bottles. The village manager confirms the kitchen is fully locked at 7pm when staff are no longer in attendance. The RN on duty has a key to access the kitchen if required. Residents cannot access the kitchen as the kitchen doors are kept closed when it is not staffed.

**Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.2 Facility Specifications**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** PA Low

Stage two: Documentation and interviews with management confirm all processes are followed to maintain a safe environment. This service completes a monthly safe and appropriate environment checklist and if any corrective actions are required these are followed up by the village manager. The facility has a current building warrant of fitness which expires on 14 March 2014.

Service reports identify that Diversey Limited check the kitchen and laundry equipment monthly. If an abnormality is identified corrective actions are taken. The laundry titration report identifies all washing machine settings are working.

Nurse call bells, smoke detector and the doorbell three monthly checks are well documented. The maintenance person completes a monthly check list of regular maintenance and a copy is sent to the village manager annually.

BV Medical check all medical equipment, such as sphygmomanometers, electric beds, and oxygen humidifiers, annually and documentation identifies that this was last undertaken on 23 March 2013. Faulty equipment is removed from service until it is deemed safe for use. For example, one leaking connection on the oxygen concentrator was replaced. This process is well documented.

 Electrical equipment was due to be checked in September 2011. This has not occurred and is an area identified for improvement.

Metlifecare Coastal Villas has a safe physical environment which minimises risk of harm by ensuring all flooring is secure, the corridors have secure handrails and the maintenance programme is implemented. Residents are observed moving around safely with or without walking aids.

Residents have access to outdoor areas with seating and shaded areas. Interviews with seven of seven residents (six hospital and one rest home) and four of four family/whanau members confirm the environment is suitable to meet their needs.

**Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.**

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Low

Electric beds are checked by BV medical for the hydraulics but electrical equipment shows that it was due to be rechecked in September 2011. This has not been undertaken.

**Finding Statement**

Electrical equipment checks are overdue.

**Corrective Action Required:**

Ensure all electrical equipment checks are undertaken to comply with legislative requirements.

**Timeframe:**

Six months

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Stage two: All hospital bedrooms have ensuite toilet and hand washing facilities. Shower areas are centrally located and in close proximity to resident bedrooms areas. Shower areas are large enough to allow residents and staff (with or without mobility aids) to move around safely. Shower doors have appropriate privacy locks and vacant engaged signs. Rest home level care apartments have full ensuite faculties. There are separate staff and visitor toilet facilities. Sanitising hand gel is located throughout the facility. All bathroom areas are maintained to high level of good repair.

As sighted, hot water temperatures are monitored monthly. The village manager confirms that if the water temperature goes over 45o Celsius in a resident area appropriate corrective actions would be taken.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.4 Personal Space/Bed Areas**

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Evaluation methods used: D 🞏 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

All 35 resident bedrooms are single occupancy. The bedrooms have adequate space to provide safe manoeuvrability with or without walking aids. As observed resident bedrooms are personalised to meet their needs. It is confirmed during interviews with seven of seven residents (six hospital and one rest home) and four of four family/whanau members that they are advised during the admission process that they are welcome to personalise their bedrooms.

**Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining**

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Evaluation methods used: D 🞏 SI 🞏 STI 🞏 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Residents are provided with safe, adequate, age appropriate accessible lounge and dining areas which are centrally located. There is a large lounge area and two dining areas, all are separate rooms. Activities are undertaken in the lounge. Residents can also access village lounge areas if they wish. Areas are furnished to meet residents' safety and comfort needs. As observed during audit and confirmed during resident and family/whanau interviews, residents are free to choose which areas they use. The village manager explained that 17 of the 32 residents have been in the village as a resident and they like to maintain ties with their friends.

**Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**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.

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🗷 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: Detailed daily cleaning schedules are sighted.

Stage two: Cleaning and laundry chemicals are supplied by Diversey Limited. There are safety data sheets located in all areas chemicals are located. Chemical storage areas are secure. All chemicals sighted are correctly labelled.

The facility looks clean and family/whanau and resident interviews confirm they are happy with cleaning and laundry services. This is confirmed in the 2012 resident satisfaction survey where cleaning gained a 96% rating which is an increase from the 93% scored in the 2011 survey result.

There are dedicated laundry and cleaning staff seven days a week. Interviews with the laundry and cleaning staff confirm they have appropriate equipment and enough time to complete all scheduled tasks.

The laundry is well equipped and has a good clean/dirty flow. The staff understand the requirements related to good infection control practices and use PPE as required. Diversey undertake monthly checks to ensure laundry and kitchen equipment are working efficiently and that the chemicals used are doing the job they are supposed to do. Regular audits are undertaken for both laundry and cleaning services and appropriate corrective actions are put in place as required.

**Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.7 Essential, Emergency, And Security Systems**

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

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: The organisation has a Disaster Management Plan in place. It states that: Metlifecare is committed to the protection of its employees, residents and facilities from the effects of a disaster, or if that is not possible, minimising such effects. Where possible and practicable, Metlifecare will also provide assistance to the external community. Contingency measures must be undertaken by each site manager to ensure that:

- The asset register for their site is kept up to date so that available physical resources can be quickly determined.

- Buildings are maintained so that provision of lighting and heating is not compromised except by circumstances beyond the control of Metlifecare.

- Employees are trained about their roles in emergencies and after emergencies.

- Hazardous substances are safe from damage in the event of earthquake or fire.

The review procedure is undertaken by the National Health and Safety Committee after practice drills and actual emergencies, seek feedback from employees and others involved, including emergency services where possible and Civil Defence if applicable, and update emergency procedures if necessary. The Fire Protection and Emergency Management policy states: Metlifecare has a Disaster Management Policy which complies with all applicable statutory requirements including fire. Emergency education is included in new staff members orientation and ongoing.

Stage two: A review of eight of eight staff files and education documentation identifies that fire evacuation and emergency training is undertaken during orientation and on-going on a six monthly basis. The facility has an approved fire evacuation scheme signed off by the fire service on 21 September 2006. There have been no changes to the building footprint since this date. The last fire evacuation was conducted on 14 July 2013 and no corrective actions were required. Fire equipment was checked in November 2012. The facility has smoke detectors and sprinklers which are linked to the fire service. Inspection of emergency equipment and lighting, fire alarms and sprinklers are carried out on a regular basis to meet legislative requirements.

Rosters identify that all shifts are covered by a staff member who holds a current first aid certificate. The call bell system is audible throughout the facility and a light is shown outside the area the bell is activated and on a location board at the nurses’ station. The nurse manager undertakes regular electronic time monitoring of how long it takes staff to respond to bells. The usual response time shown is between one to three minutes. No responses were sighted outside this timeframe. Refer comments in standard 1.3.13. Interviews with seven of seven residents (six hospital and one rest home) and four of four family/whanau members confirm staff respond in an appropriate timeframe when they ring for assistance.

The facility has emergency civil defence equipment which is checked on a regular basis. Emergency food and water are available for at least three days should it be required in case of an emergency.

Afternoon staff ensure all external doors and windows are secured and there is a night porter on site seven nights a week from 11pm to 7am who undertakes regular security checks of the exterior doors, and outdoor areas. The exterior gates to the site lock automatically at 9pm and entry can be gained by a numbered code. No code is required to exit the site.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 1.4.8 Natural Light, Ventilation, And Heating**

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🗷 CI 🗷 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: Policy identifies all Metlifecare facilities are smoke free.

Stage two: The facility is electrically heated with under floor heating. Interviews with residents and family/whanau confirm the facility is kept at a comfortable temperature throughout the year. All resident areas have at least one opening window for ventilation and natural light.

**Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS**

**OUTCOME 2.1 RESTRAINT MINIMISATION**

**STANDARD 2.1.1 Restraint minimisation**

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: Policy and procedures are in place to ensure any restraint use is actively minimised. Policy identifies enablers are voluntarily used by a consumer following appropriate assessment. When an enabler is used, consent will be sought and documented.

Stage two: At the time of audit the service has three bedside rail enablers and two restraints which are one bedside rail and one chair lap belt. During discussions with seven clinical staff they clearly demonstrate knowledge and understanding of the definition of an enabler and the processes to undertake, including monitoring, when restraint is in use.

The service is able to demonstrate a decrease in restraint use and the restraint register shows that restraint is stopped when no longer required. In May there were four enablers and four restraints and following the August review this number has been reduced to three enablers and two restraints.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**OUTCOME 2.2 SAFE RESTRAINT PRACTICE**

Consumers receive services in a safe manner.

**STANDARD 2.2.1 Restraint approval and processes**

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: Policy identifies the process for restraint approval. Each Metlifecare facility has a restraint coordinator who leads this process.

Stage two: The responsibility and accountability for restraint use and staff education is clearly outlined in the role description for the restraint coordinator. The restraint coordinator is the senior registered nurse. She leads the restraint approval group, which has a clearly documented terms of reference and the approval group reviews all restraint use on at least a three monthly basis or sooner if required. It is noted that the approval group did not meet between August 2012 and May 2013. This was the time the restraint coordinator role changed from the nurse manager to the senior registered nurse. The approval group meetings sighted for May and August 2013 following a corrective action request made in the six monthly quality review.

All restraints in use at the time of audit have been approved, monitored and updated by the approval group. The review process is clearly documented. All restraints used are for safety reasons only.

During interviews with seven of seven clinical staff they are able to verbalise their understanding of the lines of accountability for restraint use that meet policy and standard requirements.

**Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.2 Assessment**

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: Assessments for restraint is clearly shown in Policy and identifies that the need for restraint will be undertaken by suitably qualified and experienced staff. Assessment criteria sighted in policy meets all of the requirements of this criterion.

Stage two: Restraint and enabler assessment forms sighted in restraint resident file reviews (one restraint and one enabler) are completed to describe behaviour, alternatives tried, such as pain relief and music therapy, if cultural considerations have been identified, and a comprehensive checklist is completed to ensure all appropriate factors have been taken into consideration.

All RNs are competent to undertake restraint assessment. All the assessments sighted have been completed by the restraint coordinator. Prior to using restraint, assessments are sent to the approval committee to be signed off as appropriate. Staff restraint education was conducted in March 2013. A restraint competency questionnaire has been completed by 18 staff. There are still 12 staff competency questionnaires outstanding which are being followed up by the nurse manager. Assessment findings inform resident care planning. However, restraint assessment information is used in isolation and does not include other known issues not shown on the restraint assessment form. For example, one resident who is at high risk of falling has restraint in place to try to prevent falls. This resident continues to have falls and no possible alternatives are identified. The resident had four falls in June, three in July, and one to date in August. (Refer to comments in criterion 1.3.5.2). All but one of the falls occurred when the resident had their lap belt restraint in place. The restraint coordinator stated the resident was able to undo the current lap belt and that none of the falls involved unsafe restraint use. There are no alternatives to the current lap belt that is in place although the restraint coordinator stated it had been discussed but not documented. Refer comments in 2.2.4.1.

**Criterion 2.2.2.1 In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:**

 (a) Any risks related to the use of restraint;

 (b) Any underlying causes for the relevant behaviour or condition if known;

 (c) Existing advance directives the consumer may have made;

 (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;

 (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;

 (f) Maintaining culturally safe practice;

 (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);

 (h) Possible alternative intervention/strategies.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.3 Safe Restraint Use**

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

Stage one: Policy identifies that consent for restraint procedures are undertaken as described. They:

 - Must be initiated by the Restraint Coordinator; Nurse Manager or most senior nurse.

 - Must have written authority as required by the residents General Practitioner and Enduring Power of Attorney or advocate.

 - Ensure family/whanau are empowered to participate in all decisions relating to restraint through the facilitation of active support or advocacy. Restraint must be approved by a family member, the resident or resident advocate.

 - A Restraint Consent Form must be completed and filed with the resident care plan.

Each episode of restraint s required to be documented accurately to show how resident has been kept safe. Monitoring forms are required to be completed at a frequency shown on the resident care plan. Facilities must maintain a restraint register.

Stage two: Monitoring is decided according to identified risk. Currently all residents with bedside rails are on two hourly monitoring and chair lap belt restraint requires the residents to be sighted at least every hour.

All restraint is documented in the restraint register (sighted) by resident name, the date of the introduction of the restraint, and review date. Each monitored observation is recorded with the date and signature of the observer. (It is noted that not one of the resident falls have been identified in the monitoring documents sighted. Refer comments in 2.2.2.1). The use of restraint and monitoring frequency is documented on the resident's care plan. The restraint register identifies that restraint is ceased as appropriate. For example a resident who has become less mobile and does not move around the bed has had their bedside rails discontinued. This was trialled for a two week period before a decision to discontinue restraint was made. Family/whanau were involved in the decision making process to stop restraint.

**Criterion 2.2.3.2 Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:**

 (a) Only as a last resort to maintain the safety of consumers, service providers or others;

 (b) Following appropriate planning and preparation;

 (c) By the most appropriate health professional;

 (d) When the environment is appropriate and safe for successful initiation;

 (e) When adequate resources are assembled to ensure safe initiation.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:**

 (a) Details of the reasons for initiating the restraint, including the desired outcome;

 (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;

 (c) Details of any advocacy/support offered, provided or facilitated;

 (d) The outcome of the restraint;

 (e) Any injury to any person as a result of the use of restraint;

 (f) Observations and monitoring of the consumer during the restraint;

 (g) Comments resulting from the evaluation of the restraint.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 2.2.3.5 A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.4 Evaluation**

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** PA Moderate

The service has specific evaluation and review forms which cover:

- The Resident’s care plan was followed

- Alternative techniques were attempted

- The least restrictive/intrusive intervention was used

- It was the correct decision to initiate restraint and was it effective

- Associated policies & procedures were followed

- What the impact of applying restraint had for the resident, their family and the care facility

- Adequate advocacy and support was provided to those affected

- Anything new was learnt or a change in practice/training is required.

Stage two: Three monthly reviews sighted in restraint file reviews show the review is undertaken by the restraint approval group. Reviews evaluate the need for continued restraint. They do not show if the desired outcome of keeping the resident safe has been met. This is an area identified for improvement.

Restraint use is discussed with the resident and/or their family/whanau at the annual family/whanau meetings and three monthly as identified in the two resident file reviews undertaken related to restraint use.

**Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider:**

 (a) Future options to avoid the use of restraint;

 (b) Whether the consumer's service delivery plan (or crisis plan) was followed;

 (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

 (d) Whether the desired outcome was achieved;

 (e) Whether the restraint was the least restrictive option to achieve the desired outcome;

 (f) The duration of the restraint episode and whether this was for the least amount of time required;

 (g) The impact the restraint had on the consumer;

 (h) Whether appropriate advocacy/support was provided or facilitated;

 (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;

 (j) Whether the service's policies and procedures were followed;

 (k) Any suggested changes or additions required to the restraint education for service providers.

**Audit Evidence** **Attainment:** PA **Risk level for PA/UA:** Moderate

Each episode of restraint is evaluated in collaboration with the resident and family/whanau as appropriate. Whilst restraint evaluation covers most aspects of this criterion evaluations do not show that the desired outcomes to keep the resident safe is fully documented.

**Finding Statement**

Restraint is used for safety reasons and one resident who has multiply falls with recurrent injuries whilst restraint is in use, the evaluation review does not identify if the desired outcome to keep the resident safe was achieved. Falls are not acknowledged. Refer to comments in 1.3.8.3. and 2.2.2.1

**Corrective Action Required:**

Ensure restraint evaluation meets all requirements of this criterion including the identification to show that desired outcome is or is not achieved.

**Timeframe:**

Three months

**Criterion 2.2.4.2 Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 2.2.5 Restraint Monitoring and Quality Review**

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

Evaluation methods used: D 🗷 SI 🞏 STI 🞏 MI 🗷 CI 🞏 MaI 🞏 V 🞏 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Stage two: Six monthly quality reviews identify that the type, volume and frequency of restraint use is identified and trended. The progress made toward a restraint-free environment, adverse outcomes and compliance with standards and guidelines are well documented. Findings and recommendations are shown and any further action required to meet recommendations is shown. The November 2012 and May 2013 reviews identify that three monthly restraint meetings needed to be formalised. Minutes sighted show this has occurred.

The six monthly quality reviews are undertaken by the CSQRM and the report is shared with the nurse manager and staff at meetings. The restraint coordinator reports against corrective actions taken to meet deficits identified in the review. Whilst all information can be found, it is not kept together. It may be beneficial to the service to look at ways to improve this process by ensuring all restraint documentation is kept together so identification of corrective actions are more easily measured against desired outcomes.

**Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:**

 (a) The extent of restraint use and any trends;

 (b) The organisation's progress in reducing restraint;

 (c) Adverse outcomes;

 (d) Service provider compliance with policies and procedures;

 (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;

 (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;

 (g) Whether changes to policy, procedures, or guidelines are required; and

 (h) Whether there are additional education or training needs or changes required to existing education.

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS**

**STANDARD 3.1 Infection control management**

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🗷 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The aim of policy and procedures is stated as ensuring 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 Medlab South Infection Control Manual (April 2010) and Hot and Cold Food Handling Policy – Kitchen / HACCP manual.

Policy states: All employees shall:

• Be orientated in Infection Control issues relevant to their position.

• Maintain their knowledge and standards at the highest level expected for their position.

• Follow instructions regarding all Infection Control issues.

• Report any situation or practice of concern to the Nurse Manager or Infection Control Resource Nurse (ICRN).

The Infection Control Resource Nurse document identifies responsibility for co-ordination of the Infection Control Programme in the Care Facility and to assist in the development of appropriate infection control systems.

The Infection Control policy identifies that all employees shall:

• Be orientated in Infection Control issues relevant to their position.

• Maintain their knowledge and standards at the highest level expected for their position.

• Follow instructions regarding all Infection Control issues.

• Report any situation or practice of concern to the Nurse Manager or ICRN.

As stated in policy the Infection Control Programme:

• In the first instance, all aspects of infection posing risk to residents or employees shall be reported to the Nurse Manager or Registered Nurse in charge.

• The Nurse Manager / Registered Nurse in charge will be responsible for developing an appropriate plan of action following the principles of these guidelines with the advice of the Infection Control Resource Nurse (ICRN).

• ICRNs are available in each care facility for advice as to best practice. These ICRNs are also available for advice to other Metlifecare care facilities.

The facility implements the organisation wide infection prevention and control programme. The infection control resource nurse at Coastal Villas is an RN, she is assisted by two caregivers with an interest in infection control. The infection control resource nurse reports directly to the facility manager. Reporting lines and frequency are clearly defined within the policy. The resource nurse records infection rate data, and presents a monthly report to the manager and to staff meetings. The manager enters the information into the company database and all recorded information is benchmarked against other Metlifecare facilities. Notification of serious infection related issues is made to key stakeholders as stated in policy and clearly shown on a flow chart.

The role of the infection prevention and control committee is set out in their terms of reference. They are responsible to ensure on-going infection control training and prevention, implementation of the policy and procedure review and surveillance and benchmarking data to ensure the programme encompasses best practice requirements.

The role of the infection control resource nurse includes an annual review of the programme, evaluation of compliance with the programme and ensuring any corrective actions are completed, assessing staff understanding of policy and procedure, monitoring antimicrobial prescribing patterns of the GPs, and discussing any incident reports with management. Regular environmental audits, which include hand washing, are undertaken as per the audit schedule. The infection prevention and control committee is also responsible for ensuring timely reporting of notifiable diseases and notifiable outbreaks. Notifiable Disease notifications are made to the Medical Officer of Health, and other key stakeholders in accordance with contractual and compliance requirements.

Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices at entrances. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Residents suffering from infections are isolated if required and there is an isolation area designed specifically for isolation if needed.

Staff policy and notices state not to come to work when suffering from infectious diseases. If there is an outbreak staff implement actions as per outbreak planning processes in order to reduce risk of transmission of infectious diseases. The infection prevention and control policies and procedures at Metlifecare incorporate 'Bug Controls' suite of policies and procedures.

The ARC requirements are met.

**Criterion 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.2 Implementing the infection control programme**

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

The infection control committee has expertise and resources available to meet the standard requirements. The facility has adequate human, physical and information resources to implement the infection prevention and control programme. They are well supported at organisational level by the national clinical managers infection control team. Staff are kept informed of all infection control issues at monthly staff meetings. Best practice infection prevention and control principles are evident in the service provided.

The national clinical manager's team gives oversight to all infection prevention and control actions undertaken at Metlifecare facilities. External specialist advice on infection prevention and control issues is available, if and when required, from the DHB infection control nurse specialist, Medlab South, Bug Control and the Ministry of Health. The infection control resource nurse has undertaken short courses in infection control. Training is presented by specialist providers both as in-service and off site training.

The infection control resource nurse with the assistance of two caregivers, implements the organisational wide infection prevention and control programme at Metlifecare Coastal Villa. The resource nurse assesses the efficiency of the infection control measures and interventions undertaken at the facility, provides supervision of containment practices and monitors hygiene standards through the audit process. Implementation of the infection prevention and control programme is well documented in infection control reports, meeting minutes, staff training records and internal audits.

Appropriate follow-up is undertaken if issues arise from an audit, or surveillance data collected. The resource nurse is supported at organisational level by the national Metlifecare infection control expert group. Best practice infection prevention and control principles are evident in the service provided.

The ARC requirements are met.

**Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.3 Policies and procedures**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

Organisational infection prevention and control policies and procedures, supplied by Bug Control, are up-to-date and reflect current accepted good practice and legislative requirements.

Metlifecare Coastal Villas care facility is able to demonstrate implementation of all infection prevention and control policies and procedures in a manner that incorporates infection prevention and control principles in care delivery. Policies and procedures, and the infection prevention and control manual are readily accessible to all staff, are practical, easy to understand and appropriate for the scope and size of services provide.

Four of four care staff, one of one laundry and one cleaner verify infection control training at orientation and ongoing yearly. The laundry person was noted to be wearing a disposable apron and gloves, when dealing with dirty laundry. Cleaners are noted to be wearing gloves and disposable aprons. Gel is located all around the facility and noted to be used frequently. There have been no outbreaks of norovirus in the last eighteen months.

The ARC requirements are met.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.4 Education**

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🞏

**How is achievement of this standard met or not met? Attainment:** FA

All employees shall be orientated in Infection Control issues relevant to their position. Policy states: The ICRNs must attend an annual seminar, conference or similar training negotiated with their Nurse Manager to maintain relevant skills and knowledge base. She also attends quarterly meetings with the CCDHB infection control nurse.

Education on infection prevention and control to staff, is provided at orientation and on an on-going basis, both on and off site. The service ensures staff training is provided regularly on relevant infection prevention and control topics. Residents and family/whanau education is undertaken as required. Infection prevention and control education was conducted in June 2013, by the C&CDHB infection control nurse. Staff have access to both on and off site education sessions, written resources, the internet and expertise in the local community. The infection control resource nurse does ongoing education sessions as need arises, practices are observed or problems are identified.

Infection prevention and control education at orientation is sighted in the staff files reviewed. All staff interviewed confirm that infection control information and best practice principles are taught during orientation and are included in on-going staff education. Education content sighted includes, hand washing, containment, cleaning, blood/body spills, personal hygiene and correct use of sharps containers.

The organisational wide infection prevention and control education programme is evaluated annually to ensure all components are covered. Evaluations of the programmes content confirm satisfaction.

The ARC requirements are met.

**Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 3.4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**STANDARD 3.5 Surveillance**

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

Evaluation methods used: D 🗷 SI 🞏 STI 🗷 MI 🞏 CI 🞏 MaI 🞏 V 🗷 CQ 🞏 SQ 🞏 STQ 🞏 Ma 🞏 L 🗷

**How is achievement of this standard met or not met? Attainment:** FA

The organisation has a system in place to ensure infection control committees oversee and seek expert advice related to undertaking surveillance of infections to meet Health and Disability Sector standard requirements related to the complexity of the facility. Policy states: Expert and specialist advice is available from Clinical Microbiologist/Nurse Consultant – Infection Prevention & Control, Medlab South.

Annual review of programme:

• Policies and procedures (compliant with legislation and NZS 8134.1.1:2008 – Health and Disability Services (Infection Prevention and Control) Standards

• Benchmarking results

• Surveillance

• Training for employees (ICRN)

Monthly infection surveillance data are recorded, collated, trended, benchmarked and reported to management.

Surveillance data collection is undertaken for eye infections, urinary tract infections, respiratory tract infections, skin and soft tissue infections. The service also collects data on antibiotic use and informs the GPs so they can monitor this. Monthly reporting of collected data is undertaken by management, to the board and to staff meetings. Infection control data is included in annual quality assurance planning and management. The infection control resource nurse records all infections and what antibiotics are used to treat them. All staff are responsible for recording and reporting all suspected infections to the resource nurse. The resource nurse ensures infections are recorded in the individual resident's record and data is collected and monitored, evaluated and reported at management and staff meetings, as sighted in minutes. Surveillance data from the facility is benchmarked against previously collected data from other Metlifecare sites on a quarterly basis. If data indicates an increase in infectious activity the infection control resource nurse reports why this has occurred and corrective actions are put in place and completed, as and when required. An increase in urinary tract infections last year, was aligned with a reduction in fluid intake. Fluids were increased and residents informed of the need to increase their fluids and infection levels were reduced.

Standard definitions are clearly outlined in the infection prevention and control manual. Definitions classify infection events, indicators and whether or not laboratory clarification is required prior to treatment.

The ARC requirements are met.

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**

**Criterion 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.**

**Audit Evidence** **Attainment:** FA **Risk level for PA/UA:**

**Finding Statement**

**Corrective Action Required:**

**Timeframe:**