

Metlifecare Limited - Powley

Current Status: 21 November 2013

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

General overview

Metlifecare Powley is one of 23 facilities owned and operated by Metlifecare Limited. It offers hospital and rest home level care for up to 45 residents. On the day of audit there are 40 hospital and 3 rest home level care residents. There is a village on site which offers independent living. The service has applied to use up to five of these apartments, which are co-located on the ground floor, for rest home level care. In addition, two bedrooms in the care facility are to change from rest home care only, to be available for either rest home or hospital level care. The service has undertaken appropriate planning to ensure increased services are able to be safely delivered to meet residents' needs.

Four areas identified for improvement in the previous audit are now all fully attained. There are no areas identified as requiring improvement from this audit.

Audit Summary as at 21 November 2013

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 21 November 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 21 November 2013

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 as at 21 November 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 21 November 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 21 November 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 21 November 2013

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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HealthCERT Aged Residential Care Audit Report (version 3.91)

Introduction

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

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

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

Audit Report

Legal entity name:	Metlifecare Limited
Certificate name:	Metlifecare Powley
Designated Auditing Agency:	DAA
Types of audit:	Surveillance
Premises audited:	135 Connell Street, Blockhouse Bay
Services audited:	Residential Age Care Rest Home and Hospital.
Dates of audit:	Start date: 21 November 2013 End date: 21 November 2013
Proposed changes to current services (if any):	
Reconfigure services by the use of two rest home care beds for either rest home or hospital care services and an increase in capacity by five serviced apartments to provide rest home level care. These services have not been identified as requiring a verification audit and will be mentioned in this audit report as required by the HealthCERT letters dated 22 May 2013 and 27 August 2013.	
Total beds occupied across all premises included in the audit on the first day of the audit:	43

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	4
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	16	Total audit hours off site	10	Total audit hours	26
Number of residents interviewed	6	Number of staff interviewed	18	Number of managers interviewed	3
Number of residents' records reviewed	4	Number of staff records reviewed	10	Total number of managers (headcount)	2
Number of medication records reviewed	8	Total number of staff (headcount)	52	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Tuesday, 17 December 2013

Executive Summary of Audit

General Overview

Metlifecare Powley is one of 23 facilities owned and operated by Metlifecare Limited. It offers hospital and rest home level care for up to 45 residents. On the day of audit there are 40 hospital and 3 rest home level care residents. There is a village on site which offers independent living. The service has applied to use up to five of these apartments, which are co-located on the ground floor, for rest home level care. In addition, two bedrooms in the care facility are to change from rest home care only, to be available for either rest home or hospital level care. The service has undertaken appropriate planning to ensure increased services are able to be safely delivered to meet residents' needs.

Four areas identified for improvement in the previous audit are now all fully attained. There are no areas identified as requiring improvement from this audit.

Outcome 1.1: Consumer Rights

Brochures informing residents and family members of how to access independent advocacy services are displayed in the facility. The area identified as requiring improvement at the last audit now meets the standard. There is evidence of timely and ongoing communication with residents and family members. Interpreters can be access when required.

Complaints management is undertaken to comply with all requirements. There is an up to date complaints register and all complaints are overseen at organisational level via an electronic reporting system. At the time of audit there is one outstanding complaint which has been addressed and is awaiting sign off.

Outcome 1.2: Organisational Management

Organisational structures and processes are monitored by Metlifecare via an electronic system. The purpose, values, scope, direction and goals of the organisation are clearly documented and regularly reviewed. The service specific goals for Metlifecare Powley are clearly stated in the business plan and reported against quarterly at organisational level. Metlifecare Powley implements all process to ensure service delivery is planned, co-ordinated, and appropriate to the needs of the residents. This process is overseen by the nurse manager who is suitably qualified and experienced for the role. The nurse manager's job description identifies that she has the authority, accountability and responsibility for ensuring the provision of services meets residents' needs.

Quality improvements and corrective action planning is documented and outcomes are monitored for effectiveness. Key components of service delivery are explicitly linked to the quality management system and are monitored to measure achievement. There is an up-to-date risk register which outlines controls that are in place to minimise known and potential risks.

Incidents, accidents and adverse events are recorded, reported, evaluated and benchmarked. Documentation clearly states that family/whanau is kept informed and reflects the principles of open disclosure. This was an area identified for improvement in the previous audit and is now fully attained.

The service implements safe staffing levels and skill mixes that are identified as being best practice by the organisation. Human resources management processes in place meet legislative requirements. The ratio for staff to rest home and hospital level residents is managed at organisational level and if the

ratio changes the allocated nursing hours increase. This would be the case for the increase in hospital level care and if services were to include five additional rest home level care beds being approved for the attached village apartments.

Staff education is offered regularly throughout the year and attendance is recorded and monitored by the nurse manager.

Outcome 1.3: Continuum of Service Delivery

Comprehensive assessment tools are used by registered nurses to identify residents' care needs and these assessments are linked to detailed individualised care plans. Short term care plans are used when residents have new short term care needs identified. Evaluations of resident progress in meeting the care plans is documented at least three monthly and sooner when applicable and appropriate. Changes are made in the care provided to meet changing resident care needs.

There is at least one registered nurse on duty at all times. One general practitioner (GP) provides routine services for all except one of the residents. The GP visits three days a week. One of the general practitioners at the same medical practice is on call after hours and attends when required. There are effective processes used by staff to communicate the routine and changing care needs of residents with staff and the general practitioner in a timely manner.

An assessment is undertaken to identify each resident's interest, hobbies and preferred recreation activities. A range of activities are planned and provided for residents to meet these needs.

Individual resident dietary needs are identified, communicated and met. The kitchen service has been audited by Auckland City Council and holds a current 'A grade' food rating. The menu is varied has been recently reviewed by a registered dietitian with further changes to the menu in progress.

Policies and procedures related to all components of medication management including prescribing, dispensing, storage, administration and documentation is available for staff. Practices sighted comply with accepted good practice and the organisation's policy. The resident medication records sighted at audit show evidence of regular (at least three monthly) review. Processes are implemented to ensure where residents self-administer medications they are safe to do so. All staff administering medications have been assessed as competent to do so in the last 12 months.

Outcome 1.4: Safe and Appropriate Environment

The facility has an up to date building warrant of fitness. Two areas identified for improvement from the previous audit related to the safe storage of oxygen bottles and checking of fire equipment are fully attained.

Two bedrooms which the service has requested to use as either rest home or hospital are suitable for the purpose. They are spacious enough to allow the safe use of lifting equipment if required.

The service has also requested that five apartments from the attached village can be used for rest home level care, if required. This application is applicable to only the apartments on the ground floor, as this is in close proximity to the care facility. This area is suitable for rest home level care services if required.

Outcome 2: Restraint Minimisation and Safe Practice

Surveillance for residents who develop infections is occurring. The surveillance programme is appropriate to the service setting. Infections are summarised on a monthly basis and reported by category of infection. Staff are informed of residents with infections at shift handovers and overall number and types of infections are discussed at the monthly staff meeting. There is evidence of timely communication with the GP and residents' next of kin when infections are suspected or confirmed.

Metlifecare Powley currently has three bedside rails and two lap belts as restraint and four bedside rails and one lap belt as an enabler. All processes are undertaken to meet policy requirements that reflect safe restraint practices. The use of enablers is voluntary and the least restrictive option to ensure resident safety.

Outcome 3: Infection Prevention and Control

Surveillance is occurring for residents who develop infections. The surveillance is appropriate to the service setting. Staff are informed of residents with infection as a component of the shift handover processes. The overall infection rates are analysed monthly (number and type of infections) and the results communicated to staff at regular staff meetings.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	19	0	0	0	0	0
Criteria	0	43	0	0	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	31
Criteria	0	0	0	0	0	0	0	58

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

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

Attainment and Risk: FA

Evidence:

The advocacy policy and procedure (April 2012) identifies that information on advocacy services will be included in the new resident welcome pack and information will be made available to residents. During audit posters advertising independent advocacy services are sighted in public areas of the facility as well as pamphlets detailing how to access independent advocacy services. The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) posters are also sighted on the wall in residents' rooms. Six of six residents interviewed (four hospital and two rest home) and two of two family members (hospital level care residents) verify they feel sufficiently informed about advocacy or support services available. Where residents cannot recall their admission process they advise comprehensive information was provided about a large number of topics. The area identified as requiring improvement at the last audit now meets the standards. ARRC contracts requirement are met for criterion audited.

Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The resident's right to full and frank information is clearly identified in the Open Disclosure Policy. The interpreter policy details when interpreters should be accessed.

The registered nurse (RN) advises there is currently two residents with limited understanding of English. One resident who identifies their ethnicity as Russian and another resident that speaks Hindi. Both residents have family that assist with interpretation on day to day issues. Several of the staff speak Hindi and communicate with the resident about day to day activities as well

All other residents are able to speak English. The RN advises when she requires the use of a translator one is accessed via the Auckland District Health Board (ADHB). Interpreters are reported to be booked in advance when either of these two residents are scheduled for an outpatient appointment.

Incidents and adverse events are managed in an open manner and there is clear evidence of family contact in the four residents' progress notes sampled at audit. Examples sighted included open disclosure related to falls, changes in the resident's condition, need for hospitalisation, and the development of an infection.

The two family members interviewed also confirm that they (or another family member) are contacted if there are changes in a resident's health status or if an untoward event has occurred. The annual multidisciplinary meeting is an annual forum where the resident and family come and meet with the GP and other members of the health team and discuss the resident's care needs in details.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service ensures that residents, family/whanau and visitors have easy access to complaints forms. Forms are located outside the nurses' office. The complaints process is discussed as part of the admission process and a quality improvement has been put in place to include repeating this information during the annual family/whanau meetings that are held. This is confirmed during interview with two of two family/whanau members.

There is an up to date complaints register which shows the date the complaint was received, the actions taken and the outcome. This is maintained by the nurse manager. All complaints are also reported and recorded at organisational level via a computer system and monitored for effective outcomes. At the time of audit there is one outstanding complaint which the organisation's clinical quality and risk manager (CQRM) reports is awaiting confirmation from the family/whanau concerned that they are happy with all actions undertaken to resolve the complaint. Corrective action planning is clearly shown and regular updates have been sent to the family/whanau indicating the actions taken and the outcomes.

ARRC requirements are met.

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

The organisation's purpose, values, scope, direction and goals are identified in the June 2013/2014 Business Plan sighted. This plan is graduated down to show Metlifecare Powley specific goals. These are developed by the nurse manager and are matched to organisational wide goals. The goals are reviewed quarterly and reported at both facility and organisational level. Actions taken to achieve goals are clearly shown.

Interviews with two of two family/whanau members and six of six residents (four hospital and two rest home level) confirm they are very happy with the services provided and that their needs are met.

The nurse manager is a RN who has a current practising certificate. She has eight years management experience in aged care and has been at Metlifecare Powley for over two years. Her authority, accountability and responsibility for the provision of clinical care service are identified in the job description. Education and training records show that she maintains her knowledge and skills as appropriate for her role.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>Organisational quality and risk management systems are implemented at Metlifecare Powley. This is confirmed in documentation sighted and during interview with the nurse manager and CQRM who was at the audit as the organisation's representative.</p> <p>Key components of service delivery which include audit results, health and safety, accidents and incidents, complaints, hazards, infection control, restraint, training, maintenance and human resources are discussed at monthly staff meetings and quarterly RN meetings. Data collected for the key components of service are collated and presented in bar graph form at all levels of the organisation. Information gathered from incident and accident forms generate a report of the top ten risks in any given month. This information is used to inform corrective actions.</p> <p>Interviews with 18 of 18 staff (three RNs, 10 caregivers, one activities coordinator, one cook, one laundry person and two cleaners) confirm they are informed of and understand the quality and risk systems that are in place. Staff report they are informed of audit results and all key components of service delivery performance indicator data outcomes. They are aware of corrective actions that are put in place to rectify identified deficits. One example given relates to the spring cleaning audit result gaining an 86% pass rate in September 2012. The corrective actions included discussions with staff, memos to staff and a review of the spring cleaning schedule. This resulted in a 90% pass rate in March 2013 and a 97% audit pass rate in September 2013. This is confirmed in management and staff meeting minutes sighted.</p> <p>Corrective actions put in place show all actions taken and the outcomes gained. Documented quality improvements include one related to the call bells not being able to be monitored accurately owing to the printer not working. A new monitoring system was installed via the computer which allows call bells to be isolated to the pager for staff members working in a particular wing. If the bell is activated in this wing staff pagers alert them to the area the bell was rung and if they are not answered within a five minute timeframe the pager alerts are activated up in degrees to the RN and then to the nurse manager. This system is working well.</p>

Policies are managed at organisational level and updates are sent to each facility as required. All policies and procedures sighted at Metlifecare Powley are current, aligned with good practice and meet legislative requirements. The service has a document control system in place to ensure staff are aware of policy updates and changes. Policies are available to all staff in hard copy and RNs can access them via computer.

Actual and potential risks are identified, documented and where appropriate communicated to residents, family/whanau and visitors. All risks are identified in a hazard register and any new risks are discussed at staff, resident and family/whanau meetings as appropriate. Risks are monitored by the health and safety committee. This is confirmed during staff, resident and family/whanau interviews.

ARRC requirements are met.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Reporting and monitoring of essential notifications to the correct authority is fully described in policy. As sighted documentation has been completed and sent to the Ministry of Business, Innovation and Employment for two serious harm events over the past 18 months. No follow up was required. All adverse events are documented on incident and accident forms and it is clearly shown that family/whanau are informed as appropriate to reflect the principles of open disclosure. This is confirmed by documentation sighted in four of four resident file reviews (three hospital and one rest home) and during staff, resident and family/whanau interviews. All incidents and accidents are recorded electronically and trends and benchmarking is undertaken. This information is used as an opportunity to improve service delivery and manage risk via corrective action planning.

Incident and accident data is discussed at monthly staff and management meetings. If a resident has more than two falls in one month a post falls assessment is undertaken. (Sighted in resident files as appropriate). The service identifies strategies put in place in response to incidents and accidents on the incident forms and on the resident's care plan as required.

ARRC requirements are met.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Human resources management policies and practices are overseen at organisational level. They ensure all professional qualifications are validated prior to staff commencing work, for staff that require them. Thereafter the nurse manager at Metlifecare Powley ensures annual practising certificates are up to date. Practising certificates are sighted for nine RNs, six GPs, the pharmacist, one physiotherapist and one occupational therapist. Processes in place help the organisation to appoint the best person for each role to enable residents' needs to be met.

Interviews with six of six residents (four hospital and two rest home) and two of two family/whanau members confirm staff deliver services in a professional manner that meets all their needs.

A review of ten of ten staff files, (two RNs, the activities coordinator, one cook, one cleaner, one laundry and four caregivers – two from the village area and two from the care service identifies that all good human resource procedures occur. All files have job descriptions, signed contracts, orientation and education documented. One of the caregivers and one RN are newly employed and they have a comprehensive updated orientation and induction process identified in their files. The orientation is set at organisational level and the updated process includes health and safety, infection control, activities, management and administration, policies and procedures, house rules and electronic communication sections and competencies as appropriate to the role staff are employed to undertake. Two of the files reviewed are for caregivers who current work in the village area. It identifies that they hold first aid and have the opportunity to attend all planned education undertaken at the care facility.

Interviews with 18 of 18 staff confirm the orientation and induction processes offered allows them to undertake the role they are employed to do with confidence. Staff report that if a new staff member requires additional mentoring time is allocated for this.

Staff competencies are monitored by senior staff. Not all staff appraisals are current as the appraisal forms were reviewed at organisational level and have only just been approved and reprinted. However, the nurse manager has a timetable in place for all staff appraisals and appointments have been made. The nurse manager has a detailed information sheet, which she had developed to identify staff goals from their previous appraisal and these are discussed and staff report progress towards achieving this goal. Each year staff are reminded of their goals every six months to encourage them to keep working towards the things they want to achieve. Goals include education objectives and the service actively works to help staff meet their educational goals.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Metlifecare have a process in place which determines safe staffing levels. This process is implemented at Metlifecare Powley. This is confirmed in a review of four weeks rosters. Staff replacements for sickness and annual leave are clearly shown. All shifts are covered by at least one staff member with a current first aid certificate and a RN. Ten of ten staff file reviews contained up to date first aid certificates.</p> <p>Staff interviews across a range of services including clinical, housekeeping, kitchen and activities confirm that staffing levels and skill mix allows all residents' needs to be met in a timely manner and that they have time to complete all tasks each duty. The nurse manager and CQRM confirm that rostered staff numbers are adjusted to meet resident acuity levels. Resident and family/whanau interviews report all their needs are met in a timely manner.</p> <p>Discussions with the director of nursing for the Metlifecare organisation confirms that if five beds are approved at rest home level care for residents who are co-located on the ground floor of the village area, staffing levels will be increased to cater for their needs as required. The organisation has pre-approved an additional 28 hours in anticipation of this service being approved.</p>

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

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

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

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

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

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

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

Attainment and Risk: FA
Evidence: <p>All four residents' files and the ten staff files sampled by the lead auditor confirm that each stage of service provision is completed by a suitably qualified person. Annual practising certificates are sighted for applicable staff and contractors. All assessments and care plans are developed and reviewed by a registered nurse. Daily interventions and support with activities of daily living are implemented with the help of trained caregivers. The RNs maintain a book detailing when residents are due for routine GP reviews or follow-up of previously identified issues (sighted). A white board identifies when residents are due three monthly injections and which residents require blood glucose testing (and the frequency) At least three monthly reviews of the residents' progress towards meeting the care plan goals is being undertaken.</p> <p>Progress notes are completed by the RN at least daily or sooner when required in the four residents' (three hospital and one resthome) files sampled. Any changes or support interventions are documented to enable the resident to attain their goals or to work towards goals if not already attained. The monthly/three monthly GP reviews and three monthly medication reviews are evident on all ten resident medication records sampled. There is evidence of the follow-up of laboratory results and the residents response to changes in medications. Short term care plans are utilised and care plan updates are made as required (refer 1.3.5 and 1.3.6). There is evidence of regular evaluation until the care plan is closed or the care requirements transferred to the long term care plan. The RNs are responsible for the review of care plans and maintain a schedule of when these are due. Residents and family member</p>

participation is encouraged including at the MDT meetings as sighted in the four residents' files sampled.

The six residents and two family members interviewed confirm that changes are made to care provision in response to the residents' needs.

The GP interviewed confirms his involvement in specialist referrals and medication reviews and states that he is contacted about any concerns in a timely and proficient manner. The GP visits for at least three hours in the morning three days a week and is otherwise on call during business hours. After hours cover is provided by four of the GPs from the same medical practice as the primary GP who share the on call roster. The two RNs interviewed confirm the GPs are accessible and come when required. Continuity of care is maintained. Residents' files sampled evidence multidisciplinary involvement. For example, GP entries and visits from other health providers are sighted (including physiotherapist and podiatrist). Residents' files are integrated. Verbal and written handovers between shifts also ensure continuity. The afternoon handover included relevant information for the residents whose records reviewed.. Responsibilities for the provision of daily care is identified during the handover reports. The RN advises the handover sheets are updated as required and provide a good overview of residents needs for agency staff.

Hospital level care resident audited using tracer methodology:

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

Home resident audited using tracer methodology:

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

ARRC contract requirements are met.

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Interventions are documented within each component of the care plan for the four (three hospital and one rest home) residents' care plans sampled. Interventions sighted are commensurate with the completed assessments and residents' desired goals. Interventions are detailed and documented clearly

to guide staff. Residents are encouraged to be involved in developing realistic and optimal levels of functioning to meet their own everyday living needs/goals and to maintain independence. This is verified during interview with six of six residents (four hospital and two rest home level care residents) and two family members (hospital level care). The residents and family members interviewed confirm that the residents are receiving timely care to meet their identified needs. Where applicable, changes are made and communicated to/with them.

The RN discusses recent changes that have occurred for the hospital resident audited. The nursing staff (and caregivers) have been monitoring the resident's symptoms and mobility and assistance is provided based on the resident's current care needs.

Another resident has PRN pain relief prescribed. The RN has noted the need to discuss with the GP at the next visit (the day following audit) consideration of adding regular pain relief to the resident's regime. Several residents are noted to be given pro re nata (PRN) medication when required for constipation.

Short term care plans (STCPs) are being developed when a specific new problems are identified or following a reportable event. The required interventions are documented. Several residents have a short term care plan related to a urinary tract infection or respiratory infection. Another resident has a plan for a wound. Records of fully implemented and monitored interventions are sighted to have occurred.

The ARRC contract requirements are met for criterion audited.

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

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

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

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

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

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

Attainment and Risk: FA

Evidence:

The activities programme is appropriate and reflects that independence is encouraged and choices are offered. An activities assessment and plan is documented for all four residents whose records are reviewed. This identifies personal interests and hobbies. Activities are then planned to help maintain skills and interests. The 'November 2013' programme is sighted displayed in communal areas.

The activities programme is provided weekdays between 9.30 am and 4.30 pm. The activities coordinator has been in the role for six months. The activities programme includes: games, newspaper reading, cooking, games, sing-a-long/entertainment, quiz's, television/movies, church services, celebrating residents birthdays and outings. Outings occur every second Tuesday. A van is hired that can transport eight mobile residents and three residents in wheelchairs. Happy hours are also scheduled on Friday afternoons. All six residents interviewed and two family members interviewed speak highly regarding the variety of activities and outings that are provided. Preferences are considered and interests maintained. Family members are encouraged to keep social interactions with residents ongoing. One on one activities occur with residents who are no longer able to participate in most group activities.

Residents are observed participating in activities including, newspaper reading, exercise to music and cooking. The two residents audited using tracer methodology confirm being able to attend activities of choice and find them enjoyable. The hospital level resident noted a decreasing exercise tolerance. The rest home resident participated in 'everything and has a lot of fun'.

Records of attendance are kept for all activities. The activities coordinator participates in the MDT reviews as evidenced in three of four residents' files reviewed during audit. The remaining resident has been in the rest home for less than one month and is yet to have an annual MDT review.

The ARRC requirements are met for criterion audited.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

At least three monthly reviews of the residents' progress towards meeting the care plan goals is being undertaken. Progress notes are completed by the RN at least daily or sooner when required in the four residents' files sampled. Caregivers also document in the resident's file. Any changes or support interventions are documented to enable the resident to attain their goals or to work towards goals if not already attained. The monthly/three monthly GP reviews and three monthly medication reviews are evident in all four residents' files sampled. There is evidence of the follow-up of laboratory results and the residents response to changes in medications. One hospital resident audited is on a medication that requires monitoring. Blood tests are being obtained and medication adjusted as required. There is evidence blood glucose levels (BGLs) are tested for applicable residents at the frequency required and the results communicated where there are variances to expected noted. Another resident was transferred to ADHB in the few days prior to audit as having suspected seizures. The resident's changing care needs are well know to the staff on duty.

Short term care plans (STCP) are utilised and care plan updates are made as required (1.3.6). There is evidence of regular evaluation until the STCP plan is closed or the care requirements transferred to the long term care plan. The RN's are responsible for the review of care plans and maintain a schedule of when these are due. RNs are allocated individual residents to 'case manage'.

Residents and family member participation is encouraged including at the MDT meetings (where these have been held) as verified in the four resident files sampled.

The six residents and two family members interviewed confirm that changes are made to care provision in response to the residents' needs.

The relevant ARRC requirements are met.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Policies and procedure describe all required aspects of safe medicines management. Records sighted verify all RNs and four caregivers have been

assessed as competent to administer oral medications, warfarin, insulin and other injectable medications. The caregivers in the hospital and rest home do not assist with medication management. The four medication competent caregivers are working in the village area of the facility.

Policy describes that residents may self-administer medicines if they are deemed competent to do so by a RN assessment. The hospital resident audited is self administering some natural supplements. There is a current RN assessment in the resident's notes verifying the resident is competent to self administer medications. The GP has also consented for the resident to self administer medications in timeframes that comply with the organisation's policy.

Six of six residents interviewed and the two family members interviewed confirm they (or another family member) are kept informed of all changes to medications.

Ten of ten medications records reviewed have the resident's photograph present and the medication record is legible. Each entry is signed by the prescriber and the date and signature noted for all discontinued medications. Allergies are documented as being assessed on all records. Medications have been noted as reviewed by the GP in the last three months in all 10 residents' records sighted.

Medication packs are delivered monthly from the pharmacy. All packs are checked by a RN against the current medication records before being released for use. Where changes are made by prescribers after a new blister pack has been issued, the RN advises details of the changes are faxed to the pharmacy and a new pack issued. Where there are additional medications prescribed (including short course) these are dispensed in supplementary blister packs. A list is maintained of all medications returned to the pharmacy for disposal (sighted).

The GP interviewed advised during the MDT meeting all current medications (and proposed change) are discussed with the resident and family members.

Medications are safely stored in a locked medication trolley and in a locked cupboard in the nursing office. Staff are sighted carrying the keys on their person. There are several residents requiring controlled drugs. The pharmacy delivers a supply each week. These are entered into the controlled drug (CD) books and placed in the designated safe. The CD register is maintained when medications are administered. Regular weekly checks of the balance are noted.

Non-packaged medications (creams, inhalers and eye drops) are also stored safely in the medication cabinet.

A breakfast time medication round is observed with the RN and confirms administration is safely maintained, explanations provided to the residents of medications given and the administration record is documented after the resident has been observed to swallow the medications.

Two of two RNs confirm all medication errors are required to be reported and investigated

Residents' medication is reviewed on entry to the facility. This includes a medication reconciliation of the most recent resident transfer back from ADHB.

ARRC Contract requirements are met.

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Policies and procedures detail the processes required to ensure safe food handling processes in the kitchen. The main cook has been working in catering/food service industry for over 35 years and has worked at Metlifecare Powley for over 12 years. Staff in the kitchen are sighted to have completed food safety training. The kitchen and food services is audited by Auckland City Council and has an 'A grade' food rating as issued with an expiry date of 31 August 2014. The food services monitoring processes are continuing to be implemented and sighted. There is a spring and summer menu and a separate autumn and winter menu. Each have a 12 week menu which is repeated once before moving to the next menu. There is evidence a dietitian has reviewed the current menu. Recommendations made are in the process of being implemented. This is verified during interview with the Metlifecare Director of Nursing (DON). The DON provided evidence of a project committee working to update the menu (which is used across the Metlifecare network) and the follow-up dietitian review dated November 2013 sighted.</p> <p>Individual resident dietary needs are identified as part of the admission and ongoing nursing assessment process. A copy of the resident's dietary profile is provided to the kitchen and sighted. This is reported to be updated as required. Residents with special dietary needs are identified on lists in the kitchen including residents requiring</p>

a diabetic diet, soft diet, minced moist and one resident who will not eat chicken. One resident requires Hallal food and this is facilitated by the cook with meat being purchased in specifically from an approved supplier, is stored separately to other meat and is cooked in a designated pan that is reported to not be used for any other cooking.

Interview with four of four residents and family members verify that food is provided to meet individual resident's needs. Where the menu choice is not liked by a resident a substitute is provided. The serving sizes are reported to be 'more than sufficient'.

ARRC contract requirements are met.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

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

Attainment and Risk: FA
Evidence: The service undertakes documented process to ensure the safe and appropriate storage and disposal of waste and hazardous substances. There are no specific territorial authority requirements. One area identified required for improvement in the previous audit related to unsafe storage of oxygen bottles has been addressed by the service and is now fully attained.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

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.

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service undertakes all required checks for buildings, plant and emergency equipment to comply with legislation in regard to building warrant of fitness requirements. The service has a current building warrant of fitness which expires on 24 June 2014.</p> <p>The physical environment is well maintained and wide corridors; hand rails and secure flooring assist in promoting safe mobility for residents. Resident mobility needs are assessed upon admission and a mobility plan is informed by nursing staff and a physiotherapist as appropriate. This process will include rest home care services in the village apartments if they are approved for use.</p> <p>The facility is very well equipped to manage both rest home and hospital level care residents. On the day of audit one of the two bedrooms that are to go from rest home level care to 'swing' either rest home or hospital care, had lifting equipment trialled to ensure it could be manoeuvred safely including the use of the ensuite toilet. No issues were found.</p>

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Staff undertake six monthly fire drills and annual education related to fire and emergency situations. Education files confirm the 20 staff attended the last education day in October 2013. There is a civil defence cupboard and all supplies and equipment are checked monthly to ensure they are working and remain within expiry dates. Fire equipment was checked in April 2013 and are clearly labelled to show this has occurred. This was an area identified for improvement in the previous audit and is now fully attained.

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

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

Attainment and Risk: FA

Evidence:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
<p>Evidence:</p> <p>Policy clearly identifies that enablers are voluntary and that they are the least restrictive option to meet resident needs. All enablers and restraint are for safety reasons only. At the time of audit there are three bedside rails and two chair lap belt restraints and one chair lap belt and four bedside rails which are enablers.</p> <p>Staff understand the difference between restraint and enablers and this is fully covered in restraint minimisation and safe practice education presented in May and June 2013 (22 staff attended).</p> <p>All restraint process are overseen by the restraint coordinator. The organisation holds an annual restraint coordinators meeting via teleconference. This occurred in February 2013 and the restraint coordinator from Metlifecare Powley took part.</p> <p>Residents who have restraint or enablers in use have this identified in their care plan and staff are alerted via a notice board in the nurses' station and on the daily hand over sheet.</p>

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: Surveillance is occurring for residents who develop infections. The surveillance programme is appropriate to the service setting and includes the following types of infections: <ul style="list-style-type: none">- skin infections- urinary tract infections- respiratory tract infections- eye infections- gastrointestinal infections and- influenza type illness. Staff are responsible for notifying the RN who is responsible for infection prevention and control activities. An infection reporting form is completed for all

residents who are suspected or diagnosed as having an infection. The infection control nurse reviews all residents forms to ensure residents meet the criteria. Infections are summarised on a monthly basis and reported per category of infection and data for the last three months reviewed in detail. Infections sighted in the four resident files sampled are included in the surveillance data. Staff are advised of residents with suspected or known infections and the interventions required at shift handovers. Overall infection rates are reported at the monthly staff meeting.

Ten staff (including seven caregiver, two cleaners and the laundry employee) interviewed confirm they are advised of residents with infections in a timely manner via handover processes and overall infection data is communicated to them via staff meetings. The caregivers are able to identify the signs and symptoms of infection that are required to be reported to the RN.

ARCC contract requirements are met.

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

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

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

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

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

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

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