# Olive Tree Holdings Limited

## Current Status: 2 December 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

Olive Tree rest home continues to provide residential care for up to 43 residents who require rest home and dementia level care. Occupancy on the day of the audit was 42. The governing body is Olive Tree Holdings Limited. Application has been made to the Ministry of Health to increase the number of dementia level beds and decrease the number of rest home level beds. Minor building work is currently underway relating to this.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract. There has been some turnover of staff in the last 12 to 18 months although this is settling down now. There has been a new Operations and Quality Manager and a new Clinical Manager appointed since the last audit.

This audit included a review of the six aspects of service provision identified in the previous audit as requiring improvement and all these issues have been addressed.

Two areas have been identified as requiring improvement during this audit relating to the resident documentation.

## Audit Summary as at 2 December 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 2 December 2013

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

### Organisational Management as at 2 December 2013

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

### Continuum of Service Delivery as at 2 December 2013

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

### Safe and Appropriate Environment as at 2 December 2013

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

### Restraint Minimisation and Safe Practice as at 2 December 2013

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

### Infection Prevention and Control as at 2 December 2013

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

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Olive Tree Holdings Limited |
| **Certificate name:** | Olive Tree Holdings Limited |

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| **Designated Auditing Agency:** | HealthShare Limited |

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| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Olive Tree Rest Home | | | |
| **Services audited:** | Rest Home and Dementia | | | |
| **Dates of audit:** | **Start date:** | 2 December 2013 | **End date:** | 2 December 2013 |

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| **Proposed changes to current services (if any):** |
| The provider is currently reconfiguring the service to increase the number of dementia level residents by four, and decrease the number of rest home level residents by four. A new door is currently being installed to allow for this to happen. |

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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 42 |

## **Audit Team**

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

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 14 | Total audit hours | 38 |

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| Number of residents interviewed | 5 | Number of staff interviewed | 13 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 11 | Total number of staff (headcount) | 52 | Number of relatives interviewed | 1 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Wednesday, 18 December 2013

## **Executive Summary of Audit**

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| **General Overview** |
| Olive Tree rest home continues to provide residential care for up to 43 residents who require rest home and dementia level care. Occupancy on the day of the audit was 42. The governing body is Olive Tree Holdings Limited. Application has been made to the Ministry of Health to increase the number of dementia level beds and decrease the number of rest home level beds. Minor building work is currently underway relating to this.  This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract. There has been some turnover of staff in the last 12 to 18 months although this is settling down now. There has been a new Operations and Quality Manager and a new Clinical Manager appointed since the last audit.  This audit included a review of the six aspects of service provision identified in the previous audit as requiring improvement and all these issues have been addressed.  Two areas have been identified as requiring improvement during this audit relating to the resident documentation. |

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| **Outcome 1.1: Consumer Rights** |
| Open Disclosure procedures are in place to encourage staff to maintain open, transparent communication with residents and their family. Monthly newsletters are sent to residents, families of residents in the dementia unit, and any other interested parties.  A review of resident's files provides evidence communication with family is documented in whanau/family communication sheet. Residents and family interviewed confirm there is good communication between them and staff. Visual inspection provides evidence the Code of Health and Disability Services Consumers' Rights (the Code) information is displayed along with complaint forms and advocacy information.  The Operations and Quality Manager is responsible for complaints and a complaints register is maintained. The residents can use the complaints forms or bring issues up at residents' monthly meetings. Family meetings are also held in the dementia unit and family members can use this as a forum to raise any issues.   The Operations Manager advises there have been no complaints investigated by the Health and Disability Commissioner, District Health Board, Ministry of Health, Police, and Coroner since the previous audit at this facility. |

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| **Outcome 1.2: Organisational Management** |
| Olive Tree Holdings Limited is the governing body and have established systems which define the scope, direction, goals, vision, and mission statement. Systems are in place for monitoring the service provided at Olive Tree Rest Home (Olive Tree), including regular monthly reporting by the Operations and Clinical Managers to the Director, who also visits the facility three weekly.   A new Operations and Quality Manager, who is a registered nurse, was appointed in July 2013. The Operations Manager is responsible for the Olive Tree complex including the Village and apartments. A new Clinical Manager, who is a registered nurse and who has responsibility for oversight of clinical care provided, has also been appointed since the last audit. Registered nurse cover is provided seven days a week.   A written quality and risk management plan/policy identifying the organisation’s quality goals, objectives, and scope of service delivery is available. The quality and risk management plan and the business plan are used to guide service delivery and the quality programme.  There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms and are retained in individual resident's files. The two previous areas identifed as requiring improvement relating to quality and risk management documentation have been addressed. Internal audits, accident/incident forms, and meeting minutes reviewed provide evidence that corrective action plans have been developed and signed off as being completed. Regular clinical and quality and staff meetings are held and there is documented evidence of reporting on numbers of various clinical indicators, quality and risk issues, and discussion of any trends identified in these meeting minutes.   There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses and general practitioners (GPs) is occurring. Three four hour compulsory education sessions are provided for staff annually as well as monthly in-service education. Staff are also supported to attend external education as appropriate. Review of staff education records provides evidence that individual education records are maintained.   There is a documented rationale in place for determining staffing levels and skill mixes at Olive Tree. The roster is on a seven week rotating cycle and staff are rotated through the rest home and dementia areas. Registered nurse (RN) cover is provided seven days a week between 8am and 4.30pm as well as being available on call after hours. Staff report there is generally enough staff on duty and they are able to get through the work allocated to them. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The Clinical Manager and the registered nurse develop, update, and evaluate the residents' care plans at least six monthly. Residents or their family have input into the development and review of care plans. Documentation provides evidence that families are kept well informed. Residents and family interviewed report care provided by staff is very good, and the GP interviewed confirms this.   Areas requiring improvement are identified relating to care plan evaluations do not document the progress of achievement towards meeting the goals, and multidisciplinary reviews of care are not current. Areas requiring improvement from the last audit relating to pain assessments and wound management plans is now fully attained.   There are two activity programmes for the two resident groups residing in Olive Tree that supports their interests, needs and strengths. One activity co coordinator who is currently completing the diversional therapy course provides group and one to one activities mainly in the rest home. Care staff and the activities coordinator are jointly responsible for providing activities in the dementia unit. Some of the residents in the rest home area enjoy self-directed activities. There is an area requiring improvement relating to a resident who does not have an activities plan developed and implemented.   An appropriate medicine management system is implemented with policies and procedures clearly detailing service providers' responsibilities. The Clinical Manager, registered nurse, enrolled nurses, and care givers are responsible for medicine management, and have current medication competency assessments. Medication files reviewed provide evidence of documented three monthly medication reviews completed by general practitioners. This was an area requiring improvement from the last audit, and is now fully attained. There are no residents self-administering their own medication. A visual inspection of the medication systems evidence compliance with respective legislation, regulations and guidelines.   Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles and reviewed as required. Resident meetings for the rest home and family meetings include food as an agenda item. Residents and family interviewed confirm that adequate fluids are provided with extra fluid rounds, especially during the summer months, snacks are available between meals, and smoothies are made for some of the residents. The area requiring improvement from the last audit relating to the flooring in the kitchen has been addressed. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Olive Tree is purpose built and has been operating since November 1997. With the exception of three bedrooms in the dementia unit, all bedrooms have full ensuite facilities. The three bedrooms without full ensuite have wash hand basins and toilets. All bedrooms are single. Olive Tree has a current Building Warrant of Fitness displayed that expires on 31 July 2014.   Minor alterations are currently being undertaken to extend the dementia unit by four beds and reduce the rest home by four beds. Review of documentation provides evidence of a letter from New Zealand Fire Service dated 24 May 2010 approving the fire evacuation scheme for the facility. A trial evacuation was last held on 07 November 2013. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are currently no residents using restraints or enablers residing in Olive Tree. Staff interviewed have a sound knowledge of processes should residents request an enabler. All staff have received on-going education on challenging behaviour and de-escalation. Family of dementia residents have also discussed challenging behaviour at their last meeting. |

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| **Outcome 3: Infection Prevention and Control** |
| Review of documentation provides evidence the surveillance reporting process in place is applicable to the size and complexity of the organization. Results of surveillance are reported and collated for each infection each month. The Clinical Manager is the infection control co-ordinator and has completed recent infection control education. ‘Resident Infection Assessment Registers’ are maintained for all infections. Clinical indicators are reported monthly to the governing body, and reported at quality/staff/clinical meetings. Care staff interviewed report this information is available for them, and graphs are on a board in the staff room. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 15 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 2 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 59 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | 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. | PA Low | The tracer rest home resident does not have a completed activities care plan. | Provide evidence that the activities care plan for one resident is developed and implemented. | 90 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | 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. | PA Low | Not all care plans are evaluated at least six monthly and don’t always indicate the degree of achievement towards meeting the goals identified. There are interventions rather than evaluations entered in the evaluation sections. That is, evaluations have not been completed. Three of five files reviewed do not have a current multidisciplinary review of care completed. The rest home resident tracer is a recent admission and a review is not due. | Provide evidence that (i) care plan evaluations are documented, resident focused and indicate the degree of achievement towards meeting the goals;  (ii) Multidisciplinary reviews of care are completed on a regular basis. | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Open Disclosure procedures are in place to encourage staff to maintain open, transparent communication with residents and their family. Access to interpreter services is available if required.   Monthly newsletters are sent to residents, families of residents in the safe care dementia unit, and any other interested parties.  A review of resident's files (three rest home and two dementia) provides evidence communication with family is documented in resident’s notes and in whanau/family communication sheets. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms.  Residents (four rest home) and family (one dementia) interviewed confirm that staff communicate well with them. This finding is confirmed during observations by auditors on the day of this audit. Residents interviewed confirm that they are aware of the staff that are responsible for their care.  Visual inspection provides evidence the Code of Health and Disability Services Consumers' Rights (the Code) information is displayed along with complaint forms and advocacy information.  The ARC requirements are met. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has appropriate systems in place to manage the complaints process. Documentation reviewed provides evidence that the complaints processes complies with Right 10 of the Code.  The Operations and Quality Manager is responsible for complaints and a complaints register is maintained. Register reviewed and contains 10 complaints for 2013. Reporting of complaints occurs via weekly clinical and quality meetings; monthly staff meetings; and via monthly managers’ reports to the Director.   The Operations Manager advises there have been no complaints investigated by the Health and Disability Commissioner, District Health Board, Ministry of Health, Police, and Coroner since the previous audit at this facility. Complaints register reviewed and there are no complaints recorded as being received from external agencies.  Residents (four rest home) and family (one dementia unit) interviewed demonstrate an understanding and awareness of the complaints processes.  Resident meeting minutes reviewed and residents can use these to bring issues up. Family meetings are held in the dementia unit and family members can use this as a forum to raise any issues. This finding confirmed by interviews of residents and family member. A topic of interest to family members is discussed during these meetings and during the last meeting challenging behaviour was discussed.   A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of monthly quality meetings and staff meeting minutes provides evidence of reporting of complaints.  The ARC requirements are met. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Olive Tree Holdings Limited is the governing body and has established systems which define the scope, direction, goals, vision, and mission statement.  A business plan and organisational chart reviewed along with a quality improvement plan. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.  Systems are in place for monitoring the service provided at Olive Tree, including regular monthly reporting by the Operations and Clinical Managers to the Director. Reports to the Director include reporting on occupancy, staffing and human resources (HR), review of goals for the previous month and goals for the next month, internal audits, quality and risk, complaints and compliments, education, property/environmental Issues, and general comments.  A new Operations and Quality Manager was appointed in July 2013. The Operations Manager is responsible for the entire Olive Tree complex including the Village and apartments. The Operations Manager is a registered nurse with a current practising certificate. A new Clinical Manager has also been appointed since the last audit. The Clinical Manager is an experienced registered nurse who has responsibility for oversight of clinical care provided. The Clinical Manager has worked with older adults for the last 10 years in various roles including as a Clinical Nurse Specialist – Gerontology in a District Health Board (DHB), and the 12 months prior to their appointment at Olive Tree (in April 2013) as a Clinical Manager in another aged care facility.  The Clinical Manager is supported by two other registered nurses; one works four days a week and the other works 10 to 15 hours a week. These registered nurses (RN's) have current annual practising certificates. All registered nurses have undertaken training in relevant areas. Registered nurse cover is provided seven days a week.    Olive Tree Rest Home is certified to provide rest home and dementia level care. The service provider has contracts with the DHB to provide aged related residential care (rest home and dementia) and respite and day care services. The service provider also has a contract with the Ministry of Health to provide residential care for non-aged residents. There are 30 rest home and 13 dementia level care beds although the provider is currently reconfiguring the service to increase the number of dementia level residents by four, and decrease the number of rest home level residents by four. There are 30 rest home and 12 dementia level residents on the day of this audit.   The ARC requirements are met. |

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The area identified as requiring improvement during the last audit relating to corrective action plans has been addressed.  A written quality and risk management plan/policy identifying the organisation’s quality goals, objectives, and scope of service delivery reviewed during this audit and includes statements about quality activities and review processes, including internal audits. Quality and risk management plan and business plan are used to guide the service delivery and the quality programme. These documents reviewed along with documented values, mission statement and philosophy, which are displayed. Completed internal audits for 2013 reviewed along with clinical indicators for 2013.   Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed that are relevant to the scope and complexity of the service, reflects current accepted good practice, and reference legislative requirements. Systems are in place for reviewing and updating the policies and procedures regularly. Care staff interviewed confirm the policies and procedures provide appropriate guidance for them and they are advised of new policies / revised policies via their meetings and a copy is in the staff area that they are required to read and sign.  Weekly clinical and quality meetings are held as well as monthly staff meetings and resident meetings. Meeting minutes reviewed and are available for review by staff. The Operations and Clinical Managers provide the Director with monthly reports (reviewed) that include, but are not limited to, reporting on quality and risk and clinical indicators.   'Accident/Incident Forms', internal audits, staff meetings, clinical and quality meeting minutes, and resident meeting minutes reviewed provide documented evidence that corrective action plans are developed and monitored to address any areas identified as requiring improvement. There is also documented evidence in various meeting minutes that issues identified as requiring follow through are discussed at subsequent meetings.   Clinical indicators are recorded on various registers and forms and are reviewed during this audit. The Clinical Manager is responsible for collection, collation, analysis and reporting of clinical indicators. There is documented evidence of collection, collation, and reporting of quality improvement data including reporting on numbers of various clinical indicators, quality and risk issues, and discussion of any trends identified in the clinical and quality meetings as well as the monthly staff meetings. Trend analysis and graphs of clinical indicators observed attached to meeting meetings.   Staff interviewed (five care givers working morning and afternoon shifts in across both areas; one enrolled nurse and one registered nurse) report they are kept well informed of quality and risk management issues including clinical indicators. Copies of these meeting minutes are kept in the staff office for review. Graphs of clinical indicators also observed on a noticeboard in the staff room.  There is a hazard reporting system available and a hazard register. Chemical safety data sheets available identifying potential risks for each area of service. Planned maintenance and calibration programmes in place and reviewed and biomedical equipment has appropriate performance verified reports. Electrical safety stickers observed in place.  The requirements of the ARC are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The area identified as requiring improvement during the last audit relating to completion of accident and incident forms has been addressed.  Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Resident files reviewed (three rest home and two dementia) provides documented evidence of communication with family and GP on the accident/incident form, in resident progress notes, and in whanau/family communication sheets. Evidence also reviewed during this audit of notification to family of any change in the resident’s condition. This finding confirmed during interviews of residents and family member.    Corrective action plans to address areas requiring improvement are documented on accident/incident form and there is evidence of monitoring of this. Staff confirm during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions; policies and procedures; and staff education, which is confirmed via review of documentation. Staff also confirm they are completing accident / incident forms for adverse events.   The ARC requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An RN Educator is employed for a minimum of 12 hours a week to oversee the inservice education programme offered. The RN Educator is qualified and experienced educator with previous experience educating undergraduate and post graduate nurses.   Review of monthly in service education planners and staff education records for 2013 provides evidence of in service education. Three compulsory education sessions lasting four hours each are provided for all staff annually and staff are rostered off the floor to attend. These sessions are repeated twice so that all staff can attend them. Additonal inservice education sessions are also provided each month (one to two). A competency register is maintained and the register for 2013 reviewed during this audit.  Staff are also supported to complete the New Zealand Qualifications Authority (NZQA) approved National Certificate in Residential Care. All staff working in the dementia unit have either completed the dementia specific modules or are working towards completing them.   The human resource management system in place provides for the implementation of processes at the commencement of employment and ongoing in relation to staff education.    A sampling of seven staff records provides evidence human resource processes are followed e.g. reference checking, criminal vetting, completion of orientation and current performance appraisals. Individual education records are maintained. Annual practising certificates are current for all staff who require them to practice. An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents.  Five of five care givers and one enrolled nurse interviewed confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education and currency of their performance appraisals.  The ARC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery at Olive Tree. The roster is on a seven week rotating cycle and staff are rotated through the rest home and dementia areas.   Registered nurse (RN) cover is provided seven days a week between 8am and 4.30pm as well as being available on call after hours. The minimum amount of staff on duty at any one time is during the night shift between 11pm and 7.15am and consists of one caregiver in the dementia unit and two care givers in the rest home.   Care staff working all shifts in the rest home and dementia unit interviewed report that at times they feel ‘pushed’. They report this is usually when a resident is unwell or has a change in their condition. Staff also advise they discuss this with the Clinical and Operations Managers who endeavour to find additonal support. Staff report there is generally enough staff on duty and they are able to get through the work allocated to them.  Residents and family interviewed report staff provide them with adequate care.  The ARC requirements are met. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| On admission the Clinical Manager and the RN complete an initial assessment and initial care plan. Within three weeks the care plan is developed. Five of five residents’ files (three rest home and two dementia) reviewed have documentation to evidence that the resident or their family member have input into care planning. The care plans have been reviewed by the Clinical Manager and the RN within the last six months, and have recordings of monthly weights, blood pressure (BP) recordings, pulse and temperature (more frequently as clinically indicated). Communication with family sheets and progress notes are maintained, sighted in all five residents' files. All files reviewed have documentation to evidence that residents are reviewed by the GP within two working days of admission, unless they have been seen by a doctor prior to admission, usually from the DHB hospital, and three monthly thereafter if the resident is stable. Handover was observed between the morning and the afternoon care staff in both the rest home and dementia unit. The handover is both verbal and written and includes all residents. The GP who has the majority of residents residing in Olive Tree reports the RNs are very well organised. The GP reports referrals are made by fax. are prompt, that the RNs take responsibility and make very sound decisions before involving the GP.  All staff responsible for medicine management have current competency assessments.   Risk assessments, and RN assessments are completed at least six monthly. There is a combination of assessments completed in hard copy and InteRAI. An area requiring improvement from the last audit relating to pain assessments and wound management plans are addressed. Wound assessments include frequency of dressing changes and are evaluated. Short term care plans are developed, for residents who have changes in condition.   ARC requirements are met.   Tracer resident dementia:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer Rest Home:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The activity co ordinator is responsible for developing and implementing the two activity programmes, one for the rest home residents and one for the dementia residents. The programmes are varied and offer choices for residents. Entertainers visit the facility and the activities coordinator states the two groups combine for these. There are residents in the rest home who enjoy self-directed activities. The area outside the dementia unit has raised gardens where resident have planted vegetables, and there is a men’s shed.  Family and friends are welcome to attend all activities and are welcome to visit their relatives. Four of four residents in the rest home state they enjoy the activities offered (dementia resident was not able to comment). The family interviewed states they do not visit often, so couldn’t really comment. Both the activities co-ordinator and care staff in the dementia unit are jointly responsible for planned activites in the dementia unit. The auditors on the day of the audit observed a video being played for residents and a staff member dancing with a resident, and another resident going for a walk. At interview staff report activities are provided as per the programme. The operaations and quality manager reports the activities provided facility wide has been reviewed, and the intention is to employ a diversional therapist and extend the hours for residents in the dementia unit.  Five of five residents' files demonstrate that individual social profiles are completed. Activity care plans are current for four of the five residents, a rest home resident does not have an activity careplan developed. (See 1.3.7.1). The careplans demonstrate support is provided within the areas of leisure and recreation, health and well-being, and attendance records are maintained for each resident.   ARC requirements are met apart from D16.5ciii. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are two activities programmes that have been developed by the activities co coordinator. Four of five residents have activity plans that provide good detail and are evaluated at least six monthly. |
| **Finding:** |
| A rest home resident does not have a completed activities care plan. |
| **Corrective Action:** |
| Provide evidence that the activities care plan for one resident is developed and implemented. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Two of five care plans reviewed provide evidence that careplans are evaluated at least six monthy. Three of the careplans reviewed have sections where ‘Nil change’ is written, and two of the five have interventions rather than evaluations entered in the evaluation sections. That is, evaluations have not been completed. (See 1.3.8.2)  Where progress is different from what is expected, care plans are updated to reflect the changes. Changes are discussed with the GP, and short term care plans are developed and implemented.  ARC requirement are met. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Two of five care plans reviewed provide evidence that careplans are evaluated at least six monthy and evaluations indicate the degree of achievement towards meeting the goals identified. Three of the careplans reviewed have sections where only ‘Nil change’ is written, and two of the five have interventions rather than evaluations entered in the evaluation sections. That is, evaluations have not been completed. One of five files reviewed has a current multidisciplinary review of care completed. |
| **Finding:** |
| Not all careplans are evaluated at least six monthy and don’t always indicate the degree of achievement towards meeting the goals identified. There are interventions rather than evaluations entered in the evaluation sections. That is, evaluations have not been completed. Three of five files reviewed do not have a current multidiscplinary review of care completed. The rest home resident is a recent admission and a review is not due. |
| **Corrective Action:** |
| Provide evidence that (i) care plan evaluations are documented, resident focused and indicate the degree of achievement towards meeting the goals;  (ii) Multidisciplinary reviews of care are completed on a regular basis. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
| Provide evidence that when there is a change in a resident’s condition, their care plan is updated to reflect the changes. |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An appropriate medicine management system is implemented using the Robotics system. The received medicines are checked by the Clinical Manager and RN for accuracy when new packs or medicines are delivered. Medicines are stored in locked medication rooms in the rest home and dementia unit. Controlled drugs are stored in a locked metal safe, in the locked medicine room in the rest home. The controlled drugs are checked out at each administration by two staff, have a weekly count and a six monthly physical check. The medicines that require refrigeration are stored in a dedicated fridge. The temperatures are recorded weekly and are within the recommended range - sighted.   Clinical Manager,RN, ENs and caregivers are responsible for medicine management have current medication competency assessments and have attended on-going in-service education for medication management. A visual inspection of the medication systems evidences compliance with respective legislation, regulations and guidelines. Observation of the medicine round at lunch time in the rest home provides evidence that medicines are administered safely. There are currently no residents who self administer their own medicines.  Ten of the 10 medication charts reviewed evidences GPs sign for each prescribed medicine. Medicine reviews are recorded in the medicine charts where the GP signs and dates three monthly that they have reviewed the residents' medicines. This was an area requiring improvement at the last audit and is now fully attained.  The GPs conduct a medicine reconciliation when a resident is admitted to Olive Tree or if changes are made if a resident has been to an acute care hospital or a specialist. The GP who has the majority of residents, reports in their opinion medicines are managed very well, and has no concerns.  There is a specimen signature register maintained for all staff who administer medicines. The 10 medicine charts reviewed have a coloured photo of each resident to assist with the identification of the resident, and are dated and signed. All medicine charts reviewed have signing sheets for the regular medicines where a signature or reason for not giving the medicines is recorded for all entries. Audit of medicines last completed 7 September 2013.   The ARC requirements are met. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Resident's individual needs are identified on admission, documented in nutrition profiles, and reviewed on a regular basis. Menus are planned and reviewed at regular intervals by appropriately qualified service providers with specialist dietary advice. There is a six weekly menu in place that is reviewed by a dietitian.  Resident food satisfaction survey completed in June 2013 and indicated reasonable satisfaction levels. This finding confirmed during interviews of residents and family (one) where four of five residents describe the food as being of a satisfactory standard. The rest home tracer (see 1.3.3.3) describes the food as being ‘bland’. Main meal is observed during this audit and is well presented and colourful and residents observed enjoying their meals.  Adequate fluids are provided and snacks are available between meals and after hours when the kitchens are closed, e.g. fruit, bread, sandwiches, biscuits, supplements (if charted).   Five residents' files sampled (three rest home and two dementia) demonstrate regular monthly weighing and monitoring of individual’s resident’s weight and nutritional needs. Dietary profile sheets are completed on admission and copies of these are held in a folder in the kitchen. Residents care plans identify nutritional needs and interventions are documented (see link criterion 1.3.8.3). Nutritional assessments reviewed on resident's files (five). Residents are referred to a community dietitian from the local DHB via the GP's who provides oversight of management of weight loss in conjunction with the Clinical Manager. Weight loss protocols reviewed.   Visual inspection of the kitchen provides evidence of compliance with current legislation and guidelines. The previous area identified as requiring improvement relating to the flooring has been addressed as new flooring has been laid. Food service staff have completed food safety education and evidence of this is reviewed on their files. Monitoring records available include food temperatures, and fridge / freezer temperature recordings for the kitchens and are within recommended ranges.   ARC 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.

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

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

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

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

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

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

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

## **Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Olive Tree has a current Building Warrant of Fitness on display that expires on 31 July 2014. Minor alterations are currently being undertaken to extend the dementia unit by four beds and reduce the rest home by four beds. The alterations involve inserting doors along the corridor just beyond the existing dementia area and in to the rest home. A disused bathroom is currently being converted in to a pharmacy store room. Electrical equipment is observed to have current electrical safety tags in place. The facility is observed to be maintained to a high standard.  A secure external area with raised gardens, seating and shade is available in the dementia safe care unit.  ARC requirements are met. |

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

All buildings, plant, and equipment comply with legislation.

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

##### **Criterion 1.4.2.4 (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.

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

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

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

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

#### Standard 1.4.7: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Review of documentation provides evidence of a letter from New Zealand Fire Service dated 24 May 2010 approving the fire evacuation scheme for the facility. A trial evacuation was last held on 07 November 2013. The Operations Manager advises that the fire evacuation scheme does not need to be altered as a result moving the door to increase the number of dementia beds by four. Emergency training is provided for staff as part of the ongoing education programme. The policy of the organisation is to have all staff trained in first aid and there is at least one certified first aid person on each shift. Emergency equipment observed. The ARC requirements are met |

##### **Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation plan.

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Policy includes enablers and includes where the intention is to promote independence, comfort and safety and that intervention is voluntary, this constitutes an enabler. The use of an enabler must be the least restrictive option to safely meet the needs of the resident. There are currently no residents using an enabler or restraint. Documentation reviewed including consent, assessment, monitoring and review of enabler use. Staff interviewed the enabler process.  All staff have been provided with on-going education on challenging behaviour and de-escalation techniques. ARC requirement is met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control programme / policy details surveillance processes, including the surveillance objectives, priorities and methods at a level of detail that is relevant to the service setting. Review of documentation provides evidence the surveillance reporting process in place is applicable to the size and complexity of the organization. Infections are recorded and surveillance data is collected and reported on via 'Resident Infection Assessment’ monthly report forms. This acts as a register of infections and is collated at the end of each month and is reported via meetings and reports. Short term care plans are used for residents with infections and one is reviewed for a resident with a urinary tract infection (UTI).   Care staff interviewed advise they are made aware of any infections as they affect individual residents by way of feedback from the Clinical Manager, RN, via handover, and via staff meetings. They also advise clinical indicators are graphed and they discuss these at their staff meetings, and at handover. Copies of graphs and meeting minutes observed in staff areas. IC audits completed as part of the internal audit programme and reviewed for 2013. |

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

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

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

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

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

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