

# The Ultimate Care Group Limited - Oakland Lifecare

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Current Status: 4 February 2014

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

## General overview

Oakland Lifecare provides rest home and hospital level care for up to 96 residents in six wings on two floors. There are 70 residents in Oakland Lifecare on the day of this audit. The facility is operated by Ultimate Care Group Limited.

This audit includes a review of the 10 aspects of service provision identified as requiring improvement in the previous certification audit in December 2012, six of which have not been fully addressed. The areas that have not been fully addressed relate to planning of staff education; attendance of staff at management of challenging behaviour education and restraint minimisation education; management of advance directives; development and management of corrective action plans; and documentation of resident care planning where short term risk are identified.

Five new areas requiring improvement have been identified during this surveillance audit relating to; management of the complaints register; analysis of quality improvement data to identify trends; evidence of completion of orientation by new staff; some aspects of medicine management; and management of some aspects of the food service.

## Audit Summary as at 4 February 2014

Standards have been assessed and summarised below:

### Key

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

Indicator	Description	Definition
	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 4 February 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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#### Organisational Management as at 4 February 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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#### Continuum of Service Delivery as at 4 February 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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#### Safe and Appropriate Environment as at 4 February 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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#### Restraint Minimisation and Safe Practice as at 4 February 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 4 February 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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# HealthCERT Aged Residential Care Audit Report (version 3.91)

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## 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

<b>Legal entity name:</b>	Oakland Health Limited – Trading As Oakland Lifecare		
<b>Certificate name:</b>	Ultimate Care Group Ltd		
<b>Designated Auditing Agency:</b>	DAA Group Limited		
<b>Types of audit:</b>	Surveillance Audit		
<b>Premises audited:</b>	Oakland Lifecare		
<b>Services audited:</b>	Medical and Geriatric Hospital. Rest Home.		
<b>Dates of audit:</b>	<b>Start date:</b> 4 February 2014	<b>End date:</b> 4 February 2014	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			70

## Audit Team

<b>Lead Auditor</b>	XXXX	<b>Hours on site</b>	10	<b>Hours off site</b>	9
<b>Other Auditors</b>	XXXX	<b>Total hours on site</b>	10	<b>Total hours off site</b>	8
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXX			<b>Hours</b>	4

## Sample Totals

Total audit hours on site	20	Total audit hours off site	21	Total audit hours	41
Number of residents interviewed	4	Number of staff interviewed	12	Number of managers interviewed	1
Number of residents' records reviewed	6	Number of staff records reviewed	10	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	100	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

## Declaration

I, XXXXXX, Managing 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 Friday, 21 February 2014

## Executive Summary of Audit

### General Overview

Oakland Lifecare provides rest home and hospital level care for up to 96 residents in six wings on two floors. There are 70 residents in Oakland Lifecare on the day of this audit. The facility is operated by Ultimate Care Group Limited.

This audit includes a review of the 10 aspects of service provision identified as requiring improvement in the previous certification audit in December 2012, six of which have not been fully addressed. The areas that have not been fully addressed relate to planning of staff education; attendance of staff at management of challenging behaviour education and restraint minimisation education; management of advance directives; development and management of corrective action plans; and documentation of resident care planning where short term risk are identified.

Five new areas requiring improvement have been identified during this surveillance audit relating to; management of the complaints register; analysis of quality improvement data to identify trends; evidence of completion of orientation by new staff; some aspects of medicine management; and management of some aspects of the food service.

### Outcome 1.1: Consumer Rights

The area identified as requiring improvement during the last audit relating to the management of advance directives has not been fully addressed and improvements are still required. Advance directives are sighted and wishes have been signed by the resident, however in two hospital files the directive is signed by the family.

Residents and family members interviewed report that services are provided in a manner that respects residents' rights and facilitates informed choice. They report that they are happy with the service provided and that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and any significant change in a resident's condition. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is displayed along with complaint forms.

The facility manager is responsible for complaints and a complaints register is maintained although improvements are required with the management of the complaints register. The residents and their family members can use the complaints issues forms or raise issues at the residents' monthly meetings. The service provides an environment conducive to effective communication.

### Outcome 1.2: Organisational Management

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Oakland Lifecare. Planning documents reviewed include a vision statement, values, quality objectives, quality indicators and quality projects. Systems are in place for monitoring the service provided at Oakland Lifecare including regular monthly reporting by the facility manager to the Ultimate Care Group Head Office. The facility is managed by a suitably qualified and experienced facility manager who is a registered nurse with aged care experience. The facility manager is supported by a clinical services manager / registered nurse who is responsible for oversight of clinical care provided.

The Ultimate Care Group quality and risk management systems are in place at Oakland Lifecare. There is evidence that quality improvement data is collected and collated. However, there is minimal documented evidence available indicating that quality improvement data is being analysed to identify trends and improve service delivery and improvements are required. The area identified as requiring improvement during the last audit relating to corrective action plans has not been addressed and improvements are still required. There is an internal audit programme in place, risks are identified, and there is a hazard register. Adverse events are documented on accident/incident forms and an electronic database that is able to be reviewed by personnel from the Ultimate Care Group Head Office. .

There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses (RN), enrolled nurses (EN), the pharmacist, dietitian, and general practitioners (GPs) is occurring. Inservice education is provided for staff via a staff study day that staff are rostered to attend and this is supplemented by additional education sessions. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via Careerforce. Areas requiring improvement with staff education were identified during the last audit and improvements are still required with staff inservice education. Review of staff records provides evidence of human resources processes being followed (eg, reference checking, criminal record vetting, and interview questionnaires are completed), and individual education records are maintained. Improvements are required to completion of orientation by some staff.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of two registered nurses and three caregivers. The facility manager, clinical service manager or a senior registered nurse are on call after hours. All care staff interviewed report there is adequate staff available and that they are able to get through their work.

The area identified as requiring improvement during the last audit concerning staff recording their name, signature and date of entry in residents' progress notes and other documentation has been addressed. Residents' files are integrated and documentation is legible with the name and designation of the person making the entry identifiable.

### **Outcome 1.3: Continuum of Service Delivery**

Consumers participate in and receive services that are timely, planned, co-ordinated and appropriate. There is evidence that residents' needs are assessed on admission by the registered nurse (RN). Care required is identified, co-ordinated and planned in participation with the resident. All residents' files sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident, and their family, where appropriate.

Verbal handover informs care staff of residents' need and this is overseen by the registered nurse. A previous required corrective action around risk assessment and completion and evaluation of care plans has been addressed and evaluation is documented as occurring three monthly. However short term risks in three of six files reviewed, have no documentation in the care plan identifying related risk management strategies. This is a new area identified a requiring improvement.

A previous corrective action regarding the activities programme has been addressed. Activities are planned that develop and maintain interests and skills meaningful to the resident and occur five days a week.

The medication management policy is comprehensive and identifies all aspects of medicine management, including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines. However the



## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.10: Informed Consent	Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low			
HDS(C)S.2008	Criterion 1.1.10.7	Advance directives that are made available to service providers are acted on where valid.	PA Low	Advance directives are signed by relatives.	Provide documented evidence that advance directives are signed by residents themselves and those that are deemed competent by the GP where valid.	180
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S.2008	Criterion 1.1.13.3	An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	(i)The complaints register does not include all complaints received. (ii) A complaints register has not been maintained as the complaints register available only covers the period 06 May 2013 to 10 December 2013.	Provide documented evidence that the complaints register is maintained that includes all complaints, dates, and actions taken	180
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and	PA Moderate	Clinical indicators and adverse events are not	Provide documented evidence that clinical	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		evaluated and the results communicated to service providers and, where appropriate, consumers.		being critically and comprehensively analysed to identify to identify any trends.	indicators and adverse events are being critically analysed to identify any trends.	
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA High	(i)Corrective action plans are not being consistently developed to address all areas identified as requiring improvement; (ii) Corrective action plans reviewed do not consistently provide evidence that the corrective action plan has been implemented, monitored, and signed off as having been completed; and (iii) timeframes for completion of the corrective actions are not being consistently documented. (See also link criterion 1.3.12.1)	Provide documented evidence that corrective action plans are being developed, implemented, monitored, and signed off as having been completed within identified timeframes.	30
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	There is no documented evidence available on all staff files reviewed indicating that all staff have completed an orientation programme.	Provide confirmation that all new staff complete an orientation that covers the essential components of the service provided.	180
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective	PA Moderate	(i)Staff training records are disjointed and it is difficult to clearly ascertain what education	Provide documented evidence that (i) an in-service education programme is developed	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		services to consumers.		<p>has been provided for staff and what education each staff member has attended. (ii) Documented education planners for 2013 and 2014 are not available for review. (iii) Unable to evidence that medicine management education has been provided for staff involved in medicine management. It is acknowledged that medication competencies are current for staff involved in medicine management. (iv) Review of education spreadsheets and staff files indicates that not all staff have attended the staff study days which means that all staff have not completed challenging behaviour education and restraint minimisation education. (v) Not all staff have current performance appraisals.</p>	<p>and implemented that includes all key topics; (ii) staff attend in-service education; (iii) accurate records of in-service education attended are retained for each staff member; (iv) all staff involved in medicine management attend medicine management education; (v) all staff attend challenging behaviour education and all clinical staff attend restraint minimisation and safe practice education; and (vi) all staff have performance appraisals completed on a regular basis.</p>	
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	The assessment process identified short term problems requiring intervention. However none of the associated care plans made	Assessment and intervention outcomes are communicated to service providers	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				reference to these problems or the intervention required.		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA High			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA High	The medicines management system currently in place does not ensure safe and appropriate dispensing, administration and storage of medicines to comply with legislation, protocols and guidelines.	Provide evidence of implemented policies and strategies to ensure residents receive medicines in a safe and timely manner that complies with safe practice guidelines.	30
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Moderate	Aspects of food storage do not meet the required standard to comply with current legislation and guidelines.	Provide evidence of regular freezer defrosting and updated labelling on food stored in the freezer to ensure compliance with current legislation and guidelines.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

#### Evidence:

Open disclosure procedures are in place to ensure staff maintains open, transparent communication with residents and their families. Residents' files reviewed (four hospital and two rest home) provides evidence that communication with family is being documented in residents' records in 'Family/Whanau Communication Record' and in resident's progress notes. At admission the resident and their family/whanau are given information and a discussion is held to clarify what they wish to be informed about, as well as what time of day they wish to be notified for any discussion. Documentation is sighted in one of one file, where a resident requests their family is not to be informed. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, and in the individual resident's files.

Residents (three hospital and one rest home) and family (two hospital) interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that is responsible for their care. The clinical services manager (CSM) advises access to interpreter services is available if required via members of staff, the DHB and interpreter services. The CSM advises they currently have one resident with limited English and a member of staff provides interpreter services for this resident.

Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed). Residents and family confirm communication with staff is open and effective (verified in four of four resident and two of two family interviews, and sighted during audit).

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.

**Attainment and Risk:** FA

#### Evidence:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>The service provides residents and where appropriate their family / whanau with the information they need to make informed choices and give informed consent. Admission documentation clearly identifies inclusions and exclusions in the services provided. Residents are able to have their GP of choice. The registered nurse (RN) discusses information on informed consent with the resident and family/whanau on admission. An all-purpose consent form indicates the resident's agreement to collect and retain information, share medical information, approval for an influenza vaccination, the taking of a photograph for identification purposes, a name on a bedroom door, to travel in transport organised by Oakland Lifecare for outings. Two of two hospital, two of two rest home and two of two under 65 year old (YPD) files reviewed evidenced informed consent forms are signed on admission. Twelve of twelve medicine charts have residents' photographs for identification. Residents' rooms have residents' names on the door. Documentation sighted in files reviewed, identifies resident, and where desired family/whanau, are informed of any changes to care including medication changes. This is verified by interviews with four of four residents and two of two family members.</p> <p>An advance directive enables a resident to choose if they would like resuscitation in the event of cardiac, respiratory or cerebral collapse. The advanced directive is filled</p>

out in consultation with the resident's doctor and residents' wishes guide care planning, with consent or non-consent able to be revoked at any time. A previous corrective action around who signs the residents advance directive has only been partially addressed. Advance directives are sighted in two of two rest home files and two of four hospital files and wishes have been signed by the resident, however in the remaining two of four hospital files the advance directive is signed by the family. This is an area which continues to require further improvement. An interview with the clinical nurse manager identifies a review of the present advance directive form is being undertaken.

Staff education on consent takes place during study days; held quarterly throughout the year (see link criterion 1.2.7.5). Staff have an understanding of the informed consent process (confirmed in interviews with four of four care staff). Six of six residents and two of two family interviews confirm their choices are respected by staff and staff confirm they respect the resident's right to decline any services offered.

Care plans are signed by the resident and/or family/whanau, where appropriate, to say they have read and agree with what is written.

The ARC requirements are met.

#### **Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)**

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

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

#### **Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Two of two rest home and two of four hospital files have advance directives signed by residents, however two of the four hospital files have advance directives signed by relatives. This was a previous required improvement and is an area which continues to require further improvement.

**Finding:**

Advance directives are signed by relatives.

**Corrective Action:**

Provide documented evidence that advance directives are signed by residents themselves and those that are deemed competent by the GP where valid.

**Timeframe (days):** 180 (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:** PA Low

**Evidence:**

Areas requiring improvement have been identified with the management of complaints. A complaints register has not been maintained as the complaints register reviewed covers the period 6 May 2013 to 10 December 2013. Documentation for two complaints is reviewed and neither of these complaints has been entered in to the complaints register (see criterion 1.1.13.3.).

Reporting of complaints occurs via monthly meetings and via the managers' reports to the UCG Head Office. The clinical services manager (CSM) reports the complaint that was being investigated by the Health and Disability Commissioner and the District Health Board during the last audit has now been closed and they report the family are not satisfied with the outcome of the complaint investigation. The CSM advises there have been no new complaint investigations by the Health and Disability Commissioner and the District Health Board since the last audit; and that there are no complaint investigations by the Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.

Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents and their

families as part of the admission process. Residents and family interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held monthly and review of these minutes provides evidence of residents' ability to raise any issues they have. This was confirmed during interviews with residents.

A visual inspection of the facility evidences that the complaint process is readily accessible and/or displayed. Review of quality and staff meeting minutes and manager's monthly reports evidences reporting on 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> The complaints register reviewed has the first complaint recorded as being 06 May 2013 and the last complaint as 10 December 2013. A complaint form dated 14 December 2013 and an email dated 29 December 2013 are reviewed and neither of these complaints has been entered in to the complaints register. The CSM was able to provide an email response to the 29 December 2013 complaint.
<b>Finding:</b> (i) The complaints register does not include all complaints received. (ii) A complaints register has not been maintained as the complaints register available only covers the period 06 May 2013 to 10 December 2013.
<b>Corrective Action:</b> Provide documented evidence that the complaints register is maintained that includes all complaints, dates, and actions taken
<b>Timeframe (days):</b> 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

## Outcome 1.2: Organisational Management

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

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

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

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

**Attainment and Risk:** FA

#### Evidence:

The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Oakland Lifecare. A 'Quality and Risk Management Plan for Oakland Lifecare – January 2014 to January 2015' and a 'Risk Management Plan 2014' is reviewed and includes a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Also reviewed are documented values, mission statement and philosophy, which are displayed. 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.

UCG has established systems in place which defines the scope, direction and goals of the organisation and UCG facilities, as well as the monitoring and reporting processes against these systems.

There is an 'Ultimate Care Group Clinical Advisory Group' (CAG) in place that has four clinical services managers (CSMs) and is responsible for reviewing clinical issues and policies and procedures following feedback from each of the UCG sites. Each of the four CSMs is responsible for liaising with four or five UCG sites to ensure their participation in the process. 'Ultimate Care Group Clinical Governance Group Terms of Reference' are reviewed.

Meeting schedules and minutes reviewed show that monthly quality, staff, registered nurse (RN), and resident meetings are held. Meeting minutes are available for review by staff along with graphs of various clinical indicators. The facility manager (FM) provides weekly and monthly reports to the governing body. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators.

The facility manager (FM) is on holiday during this audit and the clinical services manager (CSM) is acting FM. Oakland Lifecare has a facility manager (FM) and a clinical services manager (CSM). The FM is a registered nurse with a current practising certificate and has been in this position since June 2012. The FM has spent nine of the last 12 years working in five aged care facilities as manager. The FM is supported by a CSM / registered nurse (RN) who is responsible for oversight of clinical care provided to residents. The CSM has been in this position since May 2013. Prior to being appointed as the CSM the CSM was employed as an enrolled nurse (EN) for four years and then as an RN from 2006 and as a nurse leader from 2008.

The FM's personal file is held off-site at UCG head office but their CV, practising certificate and evidence of ongoing education is able to be reviewed during this audit. Review of the CSM's personal files and interview of the CSM indicates the managers undertake training in relevant areas. Twenty four hour RN cover is provided. Support for the FM and CSM is provided by a Regional Operations Managers for UCG.

Oakland Lifecare is certified to provide medical and geriatric hospital level care and rest home level care and there are 96 beds provided. There are two rest home beds in the Pohutukawa wing that are used for either rest home or hospital use. On day one of this audit there are 45 hospital residents and 25 rest home residents. There were 12 residents aged less than 65 years on the day of this audit ranging in age from 18 to 64 years. Nine of these residents have been assessed as hospital level care and three have been assessed as requiring rest home level care.

Oakland Health Limited – trading as Oakland Health have contracts with the DHB to provide aged related residential care (rest home and hospital services); and long term support – chronic health conditions (residential). They also have a contract with the Ministry of Health to provide residential – non aged care and with Accident Compensation Corporation (ACC) to provide residential support services.

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.

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

**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.

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

### 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:** PA Moderate

#### **Evidence:**

Criterion 1.2.3.8 was partially attained during the last audit and remains partially attained as corrective action plans are not being consistently developed, implemented and monitored to address all areas requiring improvement. A further area requiring improvement has been identified as there is no evidence available to indicate that clinical indicators and adverse events are being analysed to identify any trends (see criteria 1.2.3.6 and 1.2.3.8).

The Ultimate Care Group (UCG) 'Quality and Risk Management Plan - 2012 - 2014' is used to guide the quality programme and includes quality goals and objectives. The Ultimate Care Group (UCG) quality and risk management systems are in place at Oakland Lifecare.

There is an internal audit programme in place and completed internal audits for 2013 are reviewed. Review of quality improvement data provides evidence the data is being reported to Ultimate Care Group Head Office via the UCG intranet as well as to staff via various meetings. Separate quality improvement and staff meetings are held monthly and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Registered nurse (RN) meetings are also held monthly as are resident meetings and meeting minutes are reviewed.

UCG implemented an electronic database (GOSH Inscribe database) in December 2012 which is used to input clinical indicators on a daily basis. This information is available for review by staff at UCG head office. This database is unable to be accessed during this audit but print outs of information on this database are reviewed.

The CSM advises the FM is responsible for providing 'Weekly and Monthly Report' to UCG Head Office and these include reporting of numbers of clinical indicators, education provided and internal audits completed. Other areas reported on include occupancy, staffing and HR, resident 'ins and outs', property/environmental issues, financial, general comments, and compliance/indicator summary.

Quarterly internal audits are being undertaken by the manager audit and compliance from the Ultimate Care Group to ensure compliance with the quality and risk management programme, certification requirements, and funding contract requirements. Corrective action plans are developed following these internal audits to address any improvements required and the facility is re-audited if required to achieve compliance with the standards set by the organisation. The outcomes of these audits are reported to the Board.

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service, reflects current accepted good practice, and references legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. The CAG from UCG is responsible for reviewing policies and procedures. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff (four caregivers). Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via handover and meetings.

Health & Safety Manual available that includes relevant policies and procedures. There is a hazard reporting system available as well as a hazard register. Chemical safety data sheets are available that identify potential risks for each area of service. Planned maintenance and calibration programmes are in place and are reviewed and all biomedical equipment has appropriate performance verified stickers in place.

Not all of 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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

**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.

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

**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.

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

**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.

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> Print outs from the GOSH / Inscribe data base and quality meeting minutes reviewed indicate that quality improvement data is being collected and collated and reported to staff and the governing body. A 'Summary of Clinical Indicators January – December 2013' is reviewed and is a month by month report of numbers of various clinical indicators. Month by month graphs of various clinical indicators for 2013 are reviewed during this meeting. The CSM and care staff report during interview that these

graphs are displayed on the noticeboard in the staff room. However, during visual inspection these graphs are not displayed on the noticeboard in the staff room.

**Finding:**

Clinical indicators and adverse events are not being critically and comprehensively analysed to identify to identify any trends.

**Corrective Action:**

Provide documented evidence that clinical indicators and adverse events are being critically analysed to identify any trends.

**Timeframe (days):** 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA High

**Evidence:**

This criterion was partially attained during the last audit and remains partially attained. Internal audits and meeting minutes reviewed where areas requiring improvement are identified, however corrective action plans are not being consistently developed and implemented to address all of the areas that require improvement.

Meeting minutes reviewed provide evidence that internal audits completed are reported at the next quality meeting. Meeting minutes also provide evidence that corrective action plans that have been developed for internal audits are being reported at the next quality meeting and the date of the meeting the internal audit is reported to is documented on the bottom of the internal audit form. There is documented evidence available indicating that issues identified as requiring follow through at meetings are discussed at subsequent meetings, (eg, quality, staff, RN and residents meetings). Staff interviewed report they are kept informed of quality and risk management issues including clinical indicators. Copies of meeting minutes are available for staff to review in the staff room.

<b>Finding:</b>
(i) Corrective action plans are not being consistently developed to address all areas identified as requiring improvement; (ii) Corrective action plans reviewed do not consistently provide evidence that the corrective action plan has been implemented, monitored, and signed off as having been completed; and (iii) timeframes for completion of the corrective actions are not being consistently documented. (See also link criterion 1.3.12.1)
<b>Corrective Action:</b>
Provide documented evidence that corrective action plans are being developed, implemented, monitored, and signed off as having been completed within identified timeframes.
<b>Timeframe (days):</b> 30 (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
The adverse event reporting system provides evidence of a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG GOSH / Inscribe electronic database, and filed in residents' files. An 'Incident Management Form' is used to

document all incidents that are escalated to UCG head office. 2013 data reviewed includes summaries of various clinical indicators including falls, medication errors, unintentional weight loss, skin tears, and 'behaviour'. Documentation reviewed and interviews of staff indicates appropriate management of adverse events.

There is an open disclosure policy. Resident files reviewed (four hospital and two rest home) provide evidence of communication with families following adverse events involving the resident, or any change in the resident's condition.

Staff confirm during interview that they are made aware of their essential notification responsibilities through: job descriptions; policies and procedures; and professional codes of conduct, which was confirmed via review of staff files and other documentation. Policy and Procedures comply with essential notification reporting (eg, health and safety, human resources, infection control).

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

Criterion 1.2.7.5 was partially attained during the last audit and remains partially attained. Criteria 1.4.7.2, 2.1.1.5 and 2.2.3.6 were also partially attained during the last audit and have been reported under criterion 1.2.7.5.

Written policies and procedures in relation to human resource management are available and are reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which are reviewed on staff files (10 of 10) along with reference checking, criminal record vetting, interview questionnaires, employment agreements, completed orientations and competency assessments (with exceptions noted in criterion 1.2.7.5). The validation of current annual practising certificates for registered nurses (RN), enrolled nurses (EN), the pharmacist, dietitian, and general practitioners (GPs) is occurring and the practising certificate folder is reviewed.

A registered nurse has been employed since July 2013 for four hours a week as the quality and education co-ordinator and they are interviewed during this audit. The quality and education co-ordinator is also the onsite Careerforce assessor and during interview they advise three staff have recently completed and passed the first module and that 12 more staff are enrolled to start the Careerforce aged care education modules.

Staff study days are provided every three months and staff are rostered to attend one of these study days each year. The clinical services manager (CSM) and the quality and education co-ordinator advise during interview that inservice education is also provided monthly to supplement these study days.

An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Improvements are required to completion of orientation as there is no documented evidence on all of the staff files reviewed to indicate that an orientation programme has been completed (see criterion 1.2.7.4).

Care staff interviewed (one caregiver working morning shifts, three caregivers working afternoon shifts and three RNs working all three shifts) 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.

Not all of 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>Ten staff files are reviewed and completed orientations are reviewed on four of the 10 files. The facility manager's file is held off-site and the auditor is not able to validate that they have completed an orientation. Two of the files are for staff who have recently commenced their employment and are currently working through their orientation programme. Two of the staff members commenced work in 2013 (April and July 2013), and one in December 2010 and there is no evidence on their file indicating they have completed their orientation. One of these three staff members is interviewed and advise they did complete their orientation, and they also advise they 'buddied' the</p>

staff member who commenced working in April 2013 and that this staff member did complete an orientation.

The orientation/induction programme available for new staff is reviewed and covers the essential components of the service provided (ie, the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation's vision, values & philosophy).

Staff interviewed advise they are 'buddied' for at least three days at the beginning of their orientation. The CSM advises the entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period.

**Finding:**

There is no documented evidence available on all staff files reviewed indicating that all staff have completed an orientation programme.

**Corrective Action:**

Provide confirmation that all new staff complete an orientation that covers the essential components of the service provided.

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

This criterion was partially attained during the last audit and remains partially attained.

There is evidence available indicating staff are rostered to attend one of the four full day study days, lasting 6.25 hours, that are provided throughout the year. However documentation reviewed indicates not all staff attend at least one of these study days each year. The spread sheet reviewed indicates 11 staff have not attended one of these study days and the CSM advises that some of these staff members have received letters from the FM who is following this up.

The senior administrator manages the education spreadsheets and advises they are currently transferring information from the 'old' system that was managed by the previous business manager, to a new system they implemented when they commenced in October 2013. Competencies spreadsheet is reviewed during this audit.

The FM and CSM are responsible for management of the inservice education programme and there is evidence available indicating inservice education is provided via the staff study days that are provided three monthly. The CSM and quality and education co-ordinator advise during interview that inservice education is also provided monthly to supplement the study days but there is no documented evidence available to support this.

Individual education records are not sighted on each staff member's file making it difficult to work out what education each staff member has attended.

The content of the study days is reviewed and includes sessions on challenging behaviour, infection control and hazardous waste substances, health and safety, fire safety and civil defence, quality, consumer rights, activities and restraint minimisation.

The quality and education co-ordinator and the CSM advise they have had a planning meeting with the FM to plan and develop the 2014 education planner but evidence of an education planner for 2013 and for 2014 is not available for review during this audit. Staff are supported to complete the New Zealand Qualifications Authority Unit Standards via Careerforce.

An appraisal schedule is in place and current staff appraisals sighted on three staff files reviewed. Two of the staff have not had appraisals completed yet as they have not completed their orientations. There is no evidence the CSM has a current performance appraisal. The FM's file is held off-site at Ultimate Care Group head office and evidence of completion of a current performance appraisal is unavailable. The FM was absent during this audit and was not able to be interviewed. There is no evidence of current performance appraisals on three other staff members personal files (two RNs and one cook).

**Finding:**

(i) Staff training records are disjointed and it is difficult to clearly ascertain what education has been provided for staff and what education each staff member has attended. (ii) Documented education planners for 2013 and 2014 are not available for review. (iii) Unable to evidence that medicine management education has been provided for staff involved in medicine management. It is acknowledged that medication competencies are current for staff involved in medicine management. (iv) Review of education spreadsheets and staff files indicates that not all staff have attended the staff study days which means that all staff have not completed challenging behaviour education and restraint minimisation education. (v) Not all staff have current performance appraisals.

**Corrective Action:**

Provide documented evidence that (i) an in-service education programme is developed and implemented that includes all key topics; (ii) staff attend in-service education; (iii) accurate records of in-service education attended are retained for each staff member; (iv) all staff involved in medicine management attend medicine management education; (v) all staff attend challenging behaviour education and all clinical staff attend restraint minimisation and safe practice education; and (vi) all staff have performance appraisals 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.)

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a clearly documented rationale ('Policy For Service Management') for determining service provider levels and skill mixes in order to provide safe service delivery in place at Oakland Lifecare. The staffing rationale is based on 'SNZ:HB 8163:2005 Indicators for Safe aged-care and dementia-care for Consumers' - 'Table 4 Recommended hours per consumer'. 'The Ultimate Care Group Rostering Tool' is used by the facility manager to report to UCG head office on a weekly basis. Registered nurse cover is provided 24 hours a day. The minimum amount of staff is provided during the night shift and consists of two registered nurses and three caregivers. The facility manager, clinical services manager and a senior registered nurse have a roster for who is on call after hours and this is clearly displayed on the roster for staff.

Caregivers interviewed report that there is enough staff on duty and they are able to get through the work allocated to them. Residents interviewed report there is enough staff on duty to provide them with adequate care.

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.

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

**Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)**

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service is not responsible for NHI numbers. All records sighted are secure and stored in a key pad locked office.</p> <p>The residents' records contain information to safely identify the residents, are legible and dated. Integrated notes on the resident's progress are completed at daily by care staff and reviewed by the RN as residents condition dictates. These are dated with the time of entry recorded. All current records sighted are integrated. There was one area previously identified as required improvement relating to the designation of care staff writing in progress notes to be identifiable (criterion 1.2.9.9). This is now fully attained. Progress notes sighted in six of six residents' files evidence that staff record their designation when writing in progress notes.</p>

**Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**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:**

An initial assessment, including information from the resident, their nominated representative, the needs assessment and co-ordination service and / or previous providers of personal care services is gathered and documented by the registered nurse within 24 hours of admission. This serves the basis for care planning to cover a period of up to three weeks. The long term care plan is completed by the registered nurse within three weeks of admission and includes the collection of more detailed assessment data. The long term care plan directs the care required to meet the resident's needs and desired outcomes. Progress notes are documented each shift by care staff and the RN where required. The assessments and care plan is completed and documented by the registered nurse in consultation with the resident, family and allied professionals. The care plan is evaluated every three months or as needs change to ensure the appropriate care is provided and the residents' desired outcomes are being met. Evidence of this is sighted in two of two rest home, two of two hospital and two of two YPD files reviewed.

Family contact is documented on the family contact sheet. Six of six residents, and two of two family/whanau interviewed are happy with the quality of care that is provided. One of the two family members interviewed expressed past concerns around weight loss and nutritional needs, specifically for her relatives need to be fed at mealtimes, not being met. This concern was brought to management's attention and has been addressed. Documentation in the resident's file, notes the resident's weight loss, family concerns, medical intervention around identified weight loss, nursing interventions around meal times, meal supplements and a present stabilisation in the resident's weight.

Medical assessment is conducted by the resident's general practitioner (GP) within 24 hours of admission and the treatment programme required by the resident is documented. Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. Oakland's contracted GPs visits twice a week and reviews any acute issues and/or residents requiring an ongoing review. During an interview with the one of one GP, there are concerns raised regarding the doctor's rounds. In the past the Team Leader had accompanied the doctor on the doctor's round. With promotion of the Team Leader to clinical manager, the GP has requested the clinical manager assist with the Drs round. The GP expressed confidence in the nurses assessment skills, was complimentary of the facility allowing residents to have their pets and also stated residents at times complained to her about the food. She expressed concerns in regards to the facility's management of diabetics, after observing diabetic residents receiving cakes and slices at morning and afternoon tea. (refer 1.3.13)

Registered nurses' practicing certificates and first aid certificates are sighted. Caregivers have competency certificates to administer medication in the rest home and this is sighted. The registered nurse acts as the resident's case manager and is responsible for planning, reviewing and overseeing all aspects of the resident's care. A verbal

handover by the registered nurse or senior caregiver in the rest home occurs at the beginning of each shift to ensure all staff are familiar with the residents' needs. The staff study day programme (sighted) contains the required education for the staff to meet contractual requirements. (Refer CAR 1.2.7.5). The cook has qualifications in food safety training as evidenced in personnel records. A physiotherapist provides services to the residents two and a half days per week and an occupational therapist is employed four hours each month. Two of the three activities personnel are trained diversional therapists. Evidence of all staff requiring APCs is sighted.

Health professionals delivering the daily care to residents, write in the resident's progress notes at the end of each shift. Handover of resident status is via progress notes and a verbal report at the beginning of each shift. Resident notes are integrated and demonstrate input from a variety of health professionals and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in one resident's file, where specialist input is required. Re-assessment, review and evaluation of residents and their needs is ongoing, by the RN allocated to the resident and occurs as needs change or every three months. Evaluation includes consultation with the resident, the GP, family and or advocate, to determine the resident's degree of progress towards the desired goals and initiated changes where progress differs from that expected. Changes to the plan, are evidenced to involve the resident and/or family if requested, by signage on the care plans documented communication records of phone calls or conversations. Short term care plans are used for any short term problems. Evidence of verification of the above is sighted in two of two rest home, two of two hospital, two of two YPD files and verified in four of four resident and two of two family interviews.

The ARC contract requirements are met.

Tracer methodology one – Hospital.

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

Tracer methodology two – Rest Home:

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

Tracer methodology three – Young person with a disability (hospital) –

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

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

**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.

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

### **Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)**

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

**Attainment and Risk:** PA Low

**Evidence:**

Residents' needs and deficits are identified through a variety of information sources that includes the NASC assessment, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered informs the care planning process. Within 24 hours of admission an initial assessment is undertaken by the RN to identify immediate need and plan the care required to meet these. This takes place in the privacy of the resident's bedroom with the resident and/or family/whanau present if requested. Over the next three weeks, the RN undertakes more comprehensive assessments. Formal assessments enable data to be collected around continence, hygiene, rest and sleep, skin integrity, nutrition, communication, elimination, mobility and risk of falling, memory, vision, hearing, cultural, spiritual, social, sexual, pharmaceuticals and daily activity needs. This identifies the needs outcomes and goals of residents and serves as the basis for care planning. The assessment is reviewed three monthly as needs, outcomes and goals of the resident change. A medical assessment is undertaken within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly if the GP documents the resident is stable.

Interviews with one of one rest home, one of one hospital, two of two YPD residents' and two of two family members, plus documentation in six files reviewed verify residents and family are included and informed of all assessment updates and changes. Four of four care staff and one of one RN interviewed confirm they used the information in the resident's care plan, as well as information given at handover, to ensure appropriate services and interventions are provided to meet the residents' needs.

A previous corrective action around risk assessment and completion and evaluation of care plans has been addressed and evaluation is documented as occurring three monthly. However short term risks in three of six files reviewed, has no documentation in the care plan identifying risk management strategies for these risks. A resident with a pressure area had no documentation reflecting wound care management although wound care is implemented as seen in the wound care folder. A resident with a laceration had no reference in the care plan to any wound care management taking place, though wound care is implemented. A resident who had begun to have seizures had no reference to the nursing intervention required to manage the resident's seizures or assess the effectiveness of recent medical intervention. This is a new area identified for improvement.

### **Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)**

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

**Attainment and Risk:** PA Low

**Evidence:**

Three of six files reviewed identified short term problems requiring intervention. However none of the associated care plans made reference to these problems or the intervention required.

A resident with a pressure area had no documentation reflecting wound care management although wound care is implemented as seen in the wound care folder. A resident with a laceration had no reference in the care plan to any wound care management taking place, yet it was. A resident who had begun to have seizures had no reference to the nursing intervention required to manage the seizures or to assess the effectiveness of recent medical intervention. This is an area identified for improvement

**Finding:**

The assessment process identified short term problems requiring intervention. However none of the associated care plans made reference to these problems or the intervention required.

**Corrective Action:**

Assessment and intervention outcomes are communicated to service providers

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

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

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

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

**Attainment and Risk:** FA**Evidence:**

New residents are welcomed and orientated to the facility as confirmed at interview with one of one rest home, one of one hospital, two of two YPD residents as well as two of two family members. The two of two rest home, two of two hospital and two of two YPD care plans reviewed document the desired goals to ensure delivered care and/or interventions are detailed and consistent with services required to residents' assessed needs, desired outcomes and current best practice standards.

Interviews with four of four residents expressed satisfaction with the care and the respect shown to them. Three of four residents expressed satisfaction with the food. One of those four residents preferred a salad for the evening meal over the summer months and this request has been met. The GP interviewed made reference to the GP round and diabetic diets (refer 1.3.3.3) and one of the two family members interviewed made reference to a relatives weight loss (refer 1.3.3.3), the other family member expressed satisfaction in all areas of care provided.

The DHB clinical nurse specialist and hospice nurses are available for advice, consultation and review. There is evidence of referrals to specialist services and specialists noted in consumer's files. Physiotherapy and occupational therapy services are offered on site. Referral documentation in resident's files is sighted, where specialist input is required.

Staff are observed to be respectful to residents and attend to residents needs as requested and documented in care plans on the day of the audit. The facility has access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures.

The ARC requirements are met.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>A previous corrective action regarding activities has been addressed. Activities are planned and occur regularly (9 am-3.30 pm five days per week). A variety of activities is observed on the day of the audit. On admission, residents are assessed to ascertain their needs and appropriate activity requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The activities assessments and plans' include the resident's preferences, social history, and past and present interests. The activities plans sighted match the skills, likes, dislikes and interests evidenced in the activity assessment data. The planned monthly activities programme offered is based on resident's need and requirements.</p> <p>Activities reflect ordinary patterns of life and include normal community activities (exercise groups, Zumba, happy hour, bus outings, visiting entertainers, and visits to the local returned services association club, senior citizens clubs, church services and home visits). Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate. Activities are organised and run by two diversional therapists and one diversional therapy assistant who work a total of 74 hours per week (Monday to Friday).</p> <p>Individual activity assessments, as sighted in six of six files reviewed, are updated or reviewed at least three monthly with a monthly summary of the residents response to the activities and participation recorded. The goals are developed with the resident and their family, where appropriate. Two of two YPD, one of one hospital, one of one rest home resident's and two of two family members interviewed report that they (or their relative) enjoy the activities offered.</p> <p>The ARC requirements are met.</p>

### 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Evaluation of the residents care occurs daily and is documented in the progress notes, by the care givers providing the care with direction from the RN. If any change is noted it is reported to the RN, who may contact the GP if required. The resident is included in the evaluation process and kept informed of changes in their care, as verified in four of four resident interviews. If requested family/whanau are also included and informed, as evidenced by "family contact" documentation in files reviewed.</p> <p>Formal care plan evaluation is conducted three monthly or as needs change, by the RN allocated to manage the care of that resident. Evaluation assesses the effectiveness of the care being provided to meet the resident's goals. Where progress is different from that expected, the service responds by initiating changes to the service delivery plan.</p> <p>When a resident is not responding to the services or interventions, changes are initiated to either the long term care plan, where the process is identified as one that will be ongoing or changes may be initiated on a short term basis for issues identified during assessment, such as infections, wounds, changes in mobility or changes in a resident's general condition, and a short term care plan is initiated. (Refer CAR 1.3.4)</p> <p>The RN undertakes and documents all care plan evaluations, at least every three months (sighted in all files reviewed). Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.</p> <p>The ARC requirements are met.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> PA High
<b>Evidence:</b> Medicines are dispensed and delivered by the pharmacy in Medico Pak delivery system. All medicines are prescribed by the GP. Each resident has an individual

medicines profile that includes a photograph and any documented allergies, medicine prescription form, an individually dispensed Medico Pak for their medicines and medicine signing sheets. The received medicines are checked by the RN for accuracy when new sachets or medicines are delivered. Unused or expired medications are returned to the pharmacy.

The safety of residents, visitors, staff and contactors is maintained through appropriate storage and access to medicines. Each wing has a locked secure medicine trolley to store medicines in. The medicine trolley is stored in a locked room with stock medications, medical supplies and a medicine fridge. Controlled drugs are stored in a separate locked cupboard, one on each of the two floors. Controlled drugs, when dispensed are checked by two RNs. The controlled drug register evidences weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded. The records of temperature for the medicine fridge have readings documenting temperatures; however this is not within the recommended range which is an area requiring attention.

Interview and observation of the RN undertaking medicine administration on the day of audit verified awareness of the role and responsibilities related to all aspects of medicine management. Contents of the medicine pack are observed as checked against the medicine order. Medicine charts, twelve of twelve, reviewed have each medicine signed for when dispensed (or the reason why the medicine was not given) recorded on the signing sheet. There is a specimen signature register maintained for all staff who administers medicine. The medicine charts reviewed have allergies and sensitivities recorded in a prominent position and a recent photograph of the resident for identification. Each medicine is signed individually by the GP and records date of the order, medicine, strength, dose, time, route, frequency and duration. Medicine reviews by the GPs are recorded on the medicine chart at least three monthly.

Medication errors are reported to the RN, recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. Three recent medication errors are documented. Incident forms are sighted for the incidents, no investigation or analysis is sighted at audit. This is an area identified as requiring attention. (Refer 1.2.3). Documentation is sighted verifying competency in medication management.

Approved healthcare workers are certified as competent in Medication Administration (documentation sighted), under the direction and delegation of a RN. The clinical nurse manager monitors to ensure all staff who administer medications have current competencies.

There are no residents who currently self-administer medication at Oakland.

Standing orders are used. The written authorisation (sighted), signed by the resident's GP, identifies the directions and clear indications for each medicines use. The standing order specifies the medicines that may be administered under the standing order, the treatment and condition to which the order applies, the recommended dose range, the number of doses the standing order allows, the contraindications for use, the method of administration and the documentation required. The standing order authorisation is reviewed yearly.

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.

**Attainment and Risk:** PA High

**Evidence:**

Medicines are dispensed and delivered by the pharmacy in the Medico Pak delivery system. All medicines are prescribed by the GP. Each resident has an individual medicines profile that includes a photograph and any documented allergies, medicine prescription form, an individually dispensed Medico Pak for their medicines and medicine signing sheets. The received medicines are checked by the RN for accuracy when new sachets or medicines are delivered. Unused or expired medications are returned to the pharmacy. The safety of residents, visitors, staff and contactors is maintained through appropriate storage and access to medicines. Each wing has a

locked secure medicine trolley to store medicines in. The medicine trolley is stored in a locked room with stock medications, medical supplies and a medicine fridge. Controlled drugs are stored in a separate locked cupboard, one on each of the two floors. Controlled drugs, when dispensed are checked by two RNs. The controlled drug register evidences weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded. The records of temperature for the medicine fridge have readings documenting temperatures; however this is not within the recommended range which is an area requiring attention.

Medication errors are reported to the RN, recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. Three recent medication errors are documented. Incident forms are sighted for the incidents, no investigation or analysis is sighted at audit. This is an area identified as requiring attention. (Refer 1.2.3).

**Finding:**

The medicines management system currently in place does not ensure safe and appropriate dispensing, administration and storage of medicines to comply with legislation, protocols and guidelines.

**Corrective Action:**

Provide evidence of implemented policies and strategies to ensure residents receive medicines in a safe and timely manner that complies with safe practice guidelines.

**Timeframe (days):** 30 (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:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> <p>A previous corrective action around resident dissatisfaction regarding food quality and food temperatures has been addressed. The temperatures of all cooked food is recorded when it leaves the kitchen, after being placed on hot plates and covered with insulated lids. The temperature of the cooked food is then recorded when it arrives in each wing for distribution to residents. All temperatures recorded are documented and sighted to be within the approved ranges to ensure residents receive meals at the correct temperature.</p> <p>The planned summer and winter menu (sighted) is reviewed by the dietician and as per Ultimate Care protocol reviewed every two years. The nutritional requirements are based on the Ministry of Health (MOH) food and nutritional guidelines for older people. Options for special diets are included in the menu and diabetic diets are supplied every day, sighted. Morning, afternoon tea and supper options for diabetics focus round low sugar content recipes and sandwiches.</p> <p>Sufficient staff is observed on duty in the dining room at meal times to ensure appropriate assistance is available, this is verified by interview with four of four caregiving</p>

staff and one of one RN. The dining rooms are clean, warm light and airy to enhance the eating experience.

There is evidence to support sufficient food (sighted), is ordered and prepared to meet the residents' recommended nutritional requirements. Interviews with one of one hospital, one of one rest home, two of two YPD residents and two of two family members confirm they are satisfied with the meals and meal requests. Between meal snacks are available and observed to be offered to residents

Policies and procedures guide the food and nutrition services at Oakland, with the cook and kitchen staff having qualifications in food safety (sighted). All food is ordered by the food services manager on a weekly basis. Fridge, freezer, dishwasher and cooked meat temperatures are monitored daily. Temperature records are reviewed with the food services manager and are within accepted parameters. A cleaning schedule is sighted and documents when the cleaning is attended to. Raw meat is purchased fresh on a regular basis, is cut up prior to delivery and vacuum packed. It is stored in the chiller and does not need thawing. Any leftovers are covered and labelled with the date/time/contents. Leftovers are not reheated more than once and are discarded if older than two days. Separate chopping boards and utensils are used when preparing raw foods that requires cooking.

The walk in freezer has large icicles hanging from the pipes, a large build-up of ice on the floor and shelves are overflowing. The frozen goods in the freezer have no indicator to inform how long they have been frozen. There is no system to verify when the freezer is defrosted. The cook states "management needs to give us time to attend to this and verifies there is no way of knowing how long the items in the back of the freezer have been there". This is an area which requires further attention.

A dietary assessment is undertaken for each resident on admission to Oakland and a dietary profile developed. Dietary profiles are retained in the kitchen, sighted. Every resident has a colour coded card with dislikes and special diet requirements that is placed on each resident's tray, dictating what is served. All meals are served up in the kitchen on hot plates and covered with insulated lids and transported on trolleys to the wings. In cases where some residents request the meal to be very hot, microwaves in each dining room enable staff to reheat meals.

The ARC 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> PA Moderate
<p><b>Evidence:</b></p> <p>Policies and procedures guide the food and nutrition services at Oakland, with the cook and kitchen staff having qualifications in food safety (sighted). All food is ordered by the food services manager on a weekly basis. Fridge, freezer, dishwasher and cooked meat temperatures are monitored daily. Temperature records are reviewed with the food services manager and are within accepted parameters. A cleaning schedule is sighted and documents when the cleaning is attended to. Raw meat is purchased fresh on a regular basis, is cut up prior to delivery and vacuum packed. It is stored in the chiller and does not need thawing. Any leftovers are covered and labelled with the date/time/contents. Leftovers are not reheated more than once and are discarded if older than two days. Separate chopping boards and utensils are used when preparing raw foods that requires cooking.</p> <p>The walk in freezer has large icicles hanging from the pipes, a large build-up of ice on the floor and shelves are overflowing. The frozen goods in the freezer have no indicator to inform how long they have been frozen. There is no system to verify when the freezer is defrosted. The cook states “management needs to give us time to attend to this and verifies there is no way of knowing how long the items in the back of the freezer have been there”. This is an area which requires further attention.</p>
<p><b>Finding:</b></p> <p>Aspects of food storage do not meet the required standard to comply with current legislation and guidelines.</p>
<p><b>Corrective Action:</b></p> <p>Provide evidence of regular freezer defrosting and updated labelling on food stored in the freezer to ensure compliance with current legislation and guidelines.</p>
<b>Timeframe (days):</b> 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The clinical services manager advises there have not been any alterations to the building since the last. A Building Warrant of Fitness is displayed at the main entrance that expires on 6 January 2015.

### 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.)*

## **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:**

Criterion 1.4.7.2 was partially attained during the last audit and has now been addressed as all registered nurses have current first aid certificates. Six of six registered nurse files reviewed have evidence of current first aid certificates. Register of staff with current first aid certificates is reviewed and includes registered nurses, maintenance, activities personnel and physiotherapist.

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

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## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Criterion 2.1.1.5 was partially attained during the last audit and has been transferred to criterion 1.2.7.5. The issue identified during the last audit relating to all staff receiving management of challenging behaviours education remains.

The Policy sighted states the use of enablers as “voluntary use of equipment by a resident that limits normal freedom of movement with the intention of promoting independence, comfort of safety”. There are three residents using enablers at Oakland at the time of audit. One of one file is reviewed of a resident who’s requested the use of a bed rail as an enabler. The resident’s file has a documented request by the resident requesting the use of a bed rail on her bed to assist her with mobility when in bed, an assessment of the need for the enabler, approval for the use of the bed rail by the approval group, evidence of ongoing three monthly review and evaluation, and evidence of monitoring the resident when the enabler is being used.

As confirmed by the restraint coordinator, residents who use enablers have them in place to allow the resident to maintain maximum independence. The residents using enablers at Oakland are mentally alert and can ask for assistance appropriately. An interview with the resident verifies her request to use the bed rail.

The ARC requirements are 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> In line with Oakland's infection control policy and procedures, monthly surveillance is occurring. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form. These are collated each month and presented to the Continuous Quality Improvement (CQI) meeting and registered nurses meeting and analysed to identify any significant trends or possible causative factors. Any actions required are implemented. Outcomes are presented to staff at daily handover and staff meetings and any necessary corrective actions discussed. Graphs of infection rates are displayed in the staff room.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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