

Metlifecare Limited - Highlands

Current Status: 6 May 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

Highlands Hospital is owned and operated by Metlifecare Limited. It is a complex which has 41 beds. On the day of audit there are four rest home level care and 33 hospital level care residents. There is a village on site and five apartments have been approved as appropriate for rest home level care residents. None of these five beds have been utilised to date.

All clinical care services are overseen by the nurse manager who is a registered nurse with previous experienced in the aged care sector. She is supported by a village manager who looks after non-clinical areas. On the day of audit the organisation was represented by the Metlifecare clinical quality and risk manager.

Nine of eleven areas identified for improvement in the previous audit have been addressed by the service and are now fully attained.

Three new areas requiring improvement were identified related to sharing of quality and risk information, corrective action planning documentation, documentation and content of educational material, including infection control. The documentation of educational material related to infection control and complaints management are two areas which remain open from the previous audit.

Audit Summary as at 6 May 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

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

Consumer Rights as at 6 May 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 medium or high risk and/or unattained and of low risk.
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Organisational Management as at 6 May 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 low risk.
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Continuum of Service Delivery as at 6 May 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 6 May 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 6 May 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 6 May 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>Some standards applicable to this service partially attained and of low risk.</p>
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HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Metlifecare Limited
Certificate name:	Metlifecare Limited - Highlands
Designated Auditing Agency:	The DAA Group Limited
Types of audit:	Surveillance Audit
Premises audited:	Highlands Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 6 May 2014 End date: 6 May 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	37

Audit Team

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

Sample Totals

Total audit hours on site	16	Total audit hours off site	10	Total audit hours	26
Number of residents interviewed	5	Number of staff interviewed	10	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	10	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	59	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Wednesday, 21 May 2014

Executive Summary of Audit

General Overview

Highlands Hospital is owned and operated by Metlifecare Limited. It is a complex which has 41 beds. On the day of audit there are four rest home level care and 33 hospital level care residents. There is a village on site and five apartments have been approved as appropriate for rest home level care residents. None of these five beds have been utilised to date.

All clinical care services are overseen by the nurse manager who is a registered nurse with previous experienced in the aged care sector. She is supported by a village manager who looks after non-clinical areas. On the day of audit the organisation was represented by the Metlifecare clinical quality and risk manager.

Nine of eleven areas identified for improvement in the previous audit have been addressed by the service and are now fully attained. Three new areas requiring improvement were identified related to sharing of quality and risk information, corrective action planning documentation, documentation and content of educational material, including infection control. The documentation of educational material related to infection control and complaints management are two areas which remain open from the previous audit.

Outcome 1.1: Consumer Rights

Four of five areas identified for improvement in the previous audit have been addressed and are now fully attained. Issues found related to lack of evidence available on the content of education provided is identified in the organisational management section. Staff education covers abuse and neglect, informed consent, advocacy and support. Staff interviews confirm their knowledge and understanding of ensuring all residents' rights are met.

The organisation respects and supports the right of the resident to make a complaint. The service has a complaints register and the information is recorded electronically in the organisations electronic reporting system. One area which was identified as requiring improvement in the previous audit relating to not all complaints being identified in the complaints register remains open.

There has been one external complaint made to the Counties Manukau District Health Board which has been fully investigated and is now closed. All corrective action follow up is completed and embedded into everyday practice. There are no outstanding complaints at the time of audit.

Services are provided in a manner that respects the Code of Health and Disability Services Consumers' Rights (the Code) and facilitates informed choice. The Code is clearly displayed. Residents and relatives interviewed expressed their satisfaction with services and believe staff are providing appropriate care and they are treated with respect and dignity. Interpreter and advocacy services are available. Residents, and where appropriate the family/whanau, are provided with information to assist them to make informed choices and give informed consent.

There is a policy documented and implemented on open disclosure and effective communication is evident and demonstrated between the nurse manager and the general practitioner interviewed. The ARRC requirements and the obligations of the Code are met.

Outcome 1.2: Organisational Management

At governance level there are processes in place to ensure services are planned, co-ordinated and appropriate to the needs of residents. This process is overseen by the nurse manager who is supported by the village manager; both are appropriately qualified and experienced to undertake their roles.

The service has a well-established quality and risk management systems which is understood by staff. On the day of audit no evidence could be found related to the sharing of all quality and risk data with staff and no corrective action planning documentation could be located. These are two areas identified for improvement.

Two areas that were identified for improvement in the previous audit have been fully attained. Reporting on the business plan occurs three monthly and the service has an up to date hazard register.

Resident and family/whanau interviews confirm they are kept informed of any adverse events and this is supported by documentation sighted. There were no negative comments from residents or family/whanau on the day of audit. They confirm they are happy with the level of care provided.

Human resources management processes in place and meet legislative requirements. Staff interviews confirm they are fully supported by the organisation to maintain and improve their knowledge and skills through on-going education both onsite and offsite. Documentation sighted is not completed to a level to support that all required education has been put in place or to show that the content of the education presented during in-service education is of a standard required to match the level of services offered. This is an area identified as requiring improvement.

The service implements staffing levels and skill mixes that meet contractual requirements as identified in policy.

Outcome 1.3: Continuum of Service Delivery

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring hospital and rest home level care. Staff are trained and qualified to perform their roles and deliver all aspects of service provision. A nurse manager oversees the care and management of all residents along with a team of registered nurses (RNs). All residents are assessed on admission and assessment details are retained in the individual resident's records.

The residents' care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required, with resident and family input being sought. Short term care plans are used as required to guide service delivery for residents who have short term needs. One of the general practitioners interviewed reports that all residents are seen on admission and explained that full medical cover is provided for all residents 24 hours a day. Documentation is reviewed within timeframes as required for this service.

The activities available are appropriate for residents requiring hospital and rest home level care. The activities coordinator has completed her diversional therapy qualification and dementia care New Zealand Qualifications Authority (NZQA) papers.

Medication management systems comply with current legislation and all clinical staff involved in medicine management undergo competency assessment annually. The nurse manager and RNs are responsible for all areas of medication management and work alongside a contracted pharmacy.

The food service is prepared on site and overseen by the kitchen manager who is a qualified chef. The menu plans have been reviewed and approved by a contracted dietitian to ensure they are suitable for the elderly in residential care. Each resident is assessed by the RN on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. A copy of the nutritional profile is retained in the records and the kitchen is notified of any special food requests. Visual inspection of the kitchen evidences compliance with current legislation and guidelines. All kitchen staff have completed food safety training. Meals are provided at appropriate times of the day. Family/whanau interviewed report satisfaction with the food service provided. The previous corrective action has been completed.

Outcome 1.4: Safe and Appropriate Environment

The service has a current building warrant of fitness. There have been no changes made to the exterior footprint since the previous audit. All maintenance is signed off to show it is completed. This was an area identified for improvement in the previous audit and is now fully attained.

Outcome 2: Restraint Minimisation and Safe Practice

Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. Currently the service has two restraints in place and all processes have been completed for approval and review.

Outcome 3: Infection Prevention and Control

The infection prevention and control co-ordinator/RN participates in relevant ongoing education. In service education related to infection control is evident in the for 2013 and 2014 education calendar. Evidence is seen of the infection prevention and control (IPC) education programme being reviewed as required. The previous required corrective actions related to this have been completed. However, evidence is not seen of the content of the IPC education in-service sessions. This is a previous corrective action which has not been completed.

Surveillance for residents who develop infections is occurring. The surveillance method and definitions of infection are detailed and the surveillance is appropriate to the service setting. All residents with suspected infections are discussed with the general practitioner, registered nurse and caregivers in a timely manner. Overall infection rates and trends are collated and benchmarked as required.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	17	0	3	1	0	0
Criteria	0	40	0	4	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	29
Criteria	0	0	0	0	0	0	0	56

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 Moderate			
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 Moderate	A review of staff meeting minutes identifies that issues discussed under the complaints topic were not shown in the complaints register. The corrective actions taken are identified in the staff meeting minutes but no corrective action forms could be found and no outcome measures sighted.	Ensure all complaints are identified in the complaints register.	90
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management	The organisation has an established, documented, and maintained quality and risk	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Systems	management system that reflects continuous quality improvement principles.				
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Whilst monthly data is shared with staff no evidence could be found that benchmarked data is shared with staff. This does not allow staff to be informed of how each month compares with previously collected data.	Ensure all quality and improvement data is shared with service providers.	180
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 Low	No documented corrective action forms or quality improvements could be located on the day of audit.	Ensure corrective actions plans are completed and available to staff to show how deficits found have been addressed and what outcomes or improvements have been achieved.	180
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 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	1. Documentation sighted to say education related to informed consent (1.1.10.2) and advocacy (1.1.11.1) has been undertaken but no specific information could be found on the day of audit. No education content or staff attendance numbers could be found. Corrective action planning states all the	Ensure all planned education is accurately recorded and supported by content material to show what was delivered.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>information was provided to the District Health Board related to the previous audits identified improvements but the information could not be located.</p> <p>2. Documentation identifies that abuse and/or neglect education was offered on the 22 August 2013 and 17 staff attended. No content of the education could be located. This is related to criterion 1.1.3.7 (also refer to comment in standard 3.4).</p> <p>3. No evidence could be found to show that all documented education shown on the calendar was undertaken and only guest speaker content of educational sessions delivered could be located on the day of audit.</p>		
HDS(IPC)S.2008	Standard 3.4: Education	The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	PA Low			
HDS(IPC)S.2008	Criterion 3.4.5	Consumer education occurs in a manner that recognises and meets the communication	PA Low	The infection control nurse is not maintaining formally a record of the	Ensure the content of all education related to infection prevention and control is	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		method, style, and preference of the consumer. Where applicable a record of this education should be kept.		content of the infection education provided to staff. The previous corrective action has not been met.	documented.	

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 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

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

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

Attainment and Risk: FA

Evidence:

Organisational policy is in place related to zero tolerance of abuse and neglect. Information for staff regarding abuse and neglect of residents is undertaken two yearly as identified on the service education calendar. The organisation's Code of Conduct is included in staff employment agreements as confirmed in 10 of 10 staff file reviews. Interviews with two of two RNs and three of three caregivers identify their understanding of abuse and neglect and they voice how policy is implemented. Documentation identifies staff education occurred in August 2013 and specific RN education occurred in February 2014. This was an area identified for improvement in the previous audit related to staff education. Refer comments in criterion 1.2.7.5.

Interviews with five of five residents and two of two family/whanau members confirm services are delivered in a manner which meets their rights. No one spoken to on the day of audit has any concerns related to the manner in which care is delivered.

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Highlands Hospital policy on open disclosure defines and clearly describes what open disclosure is to guide staff. Open disclosure is required for the informed consent process, especially when there is a need of further treatment or care and is a demonstration of the philosophy of valuing residents and families as part of the team with a family centred approach to care delivery. There is an interpreter/translation policy available to guide staff on who to contact as required. The general practitioner, two RNs, and three caregivers interviewed have a good understanding of open disclosure and the resident`s right to full and frank information and open disclosure. A resident centred approach to service delivery and open communication is respected by staff. A communication book is available in all services. Family meetings are held and this was verified with two residents interviewed from the hospital and the rest home. For any complaints or investigations the resident/family/whanau would be informed of any investigations or involvement required. Handover records are used between all shifts in all service areas by staff and this system of good communication works effectively.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

Attainment and Risk: FA
Evidence: Interviews with five of five clinical staff (two registered nurses and three caregivers) confirm their knowledge and understanding of informed consent processes. Staff education related to informed consent is identified on the two yearly education calendar sighted. This was an area identified for improvement in the previous audit related to staff education. Refer comments in criterion 1.2.7.5. Interviews with five of five residents and two of two family/whanau confirm staff explain what they are going to do and that resident choices are respected. Informed consent forms sighted in five of five resident file reviews (four hospital and one rest home level care). Family/whanau state that entry documentation was fully explained to them as part of the admission process including informed consent.

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.

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

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

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

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

Attainment and Risk: FA
Evidence: Five of five clinical staff interviews report they recognise and facilitate residents' rights to advocacy and support persons. Documentation sighted identifies that education related to advocacy occurs on a regular two yearly basis. This was an area identified for improvement in the previous audit related to staff education. Refer comments in criterion 1.2.7.5. Two of two family/whanau report they are invited to have input in their relatives care. Five of five residents confirm they are supported to have the person of their choice with them when care planning or care changes are being discussed. Information related to advocacy services is on display at the entrance to the facility and is easily accessible.

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

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

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

Standard 1.1.13: 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 Moderate
Evidence: <p>Metlifecare Highlands Hospital implements organisational policies and procedures to ensure complaints processes are in place related to easily accessed information for residents and visitors. Interviews with five of five residents and two of two family/whanau members confirms the process was explained to them and they are aware of where to access complaints forms or which staff members to talk to if they have any issues.</p> <p>The service has a complaints register in place which identifies the nature of the complaint, the dates received and the actions taken. Information is used to improve services as appropriate. The complaints in the register are also logged into the organisation's electronic register and are monitored for outcomes by the head office. This was an area identified for improvement in the previous audit and is now fully attained. However not all complaints sighted are documented in the complaints register. This was an area identified for improvement in the previous audit and remains open.</p> <p>The RN and village manager confirm there are no known outstanding complaints at the time of audit.</p>

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

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

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

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

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

Attainment and Risk: PA Moderate
<p>Evidence:</p> <p>The service has a complaints register in place and the complaints in the register are logged onto the organisation's electronic register and followed up for outcomes via head office. This was an area identified for improvement in the previous audit and is now fully attained.</p> <p>One complaint registered with the Counties Manukau District Health Board related to food services has been fully reviewed and all appropriate corrective actions have been undertaken. This includes:</p> <ul style="list-style-type: none"> - the appointment of a registered dietitian who has approved the current menu as meeting the New Zealand Ministry of Health Food and Nutritional Guidelines for Healthy Older People - The menu review occurred in November 2013 - A letter of acknowledgement that all specialist dietetic advice has been implement (sighted) - Staff responsible for preparing and serving meals and fluids have regular ongoing education from the dietitian. <p>Monthly dietitian assessment and review meetings are very well documented and information is shown in the resident's progress notes. One example relates to a resident with elevated cholesterol who is below average weight. The dietitian identifies a change in supplementary foods, a current weight chart identifies the resident is maintaining their current weight and staff education is documented. The above processes are fully embedded into everyday practice.</p> <p>Complaints information is discussed at staff meetings as evidenced in meeting minutes sighted. Not all complaints sighted in the staff minutes are shown in the complaints register. This was area identified for improvement in the previous audit and remains unmet.</p>

Finding:

A review of staff meeting minutes identifies that issues discussed under the complaints topic were not shown in the complaints register. The corrective actions taken are identified in the staff meeting minutes but no corrective action forms could be found and no outcome measures sighted.

Corrective Action:

Ensure all complaints are identified in the complaints register.

Timeframe (days): 90 (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:

As an organisation, Metlifecare have an up to date business plan which identifies their purpose, value, direction and goals. At facility level, Metlifecare Highlands Hospital has specific goals which relate to the organisational plan. These are reported against quarterly to show how goals are being met.

The care facility is managed by a registered nurse (RN) who has many years aged care experience. (She was on holiday at the time of this audit). Management processes are undertaken jointly by the village manager who looks after all non-clinical areas. Both managers maintain their skills and knowledge by attendance at conferences, in-service education and regular Metlifecare senior management team (SMT) meetings.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:
Timeframe (days): <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.

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

Standard 1.2.3: 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 Low
Evidence: <p>The service uses the organisational quality and risk systems which include regular ongoing audits to identify areas where corrective actions may be required. Interviews with ten of ten staff (two RNs, three caregivers, one kitchen hand, one kitchen chef, one maintenance supervisor, one activities coordinator and one cleaner) confirm they understand quality systems and implement corrective actions as required. This is supported in staff meeting minutes sighted.</p> <p>Policies and procedures are aligned with current good practice and meet legislative requirements. All updates and reviews are undertaken by head office and there is a system in place to ensure obsolete documents are removed from service. Staff confirm they have access to all policies and procedures and that they are informed of all updated policies during staff meetings. Two areas identified for improvement in the previous audit are now fully attained.</p> <p>Key components of service delivery are linked to the quality management systems via health and safety, infection control, maintenance, grounds, kitchen, restraint, complaints and quality improvement committees and reports submitted monthly to management. This information is used to inform high level reporting of the key</p>

components shown in the business planning process which includes quality and risk. The business plan is reported against quarterly to identify if stated goals are being met.

At organisational level, actual and potential risks related to all operations of the business are identified, documented and communicated to residents, family/whanau and staff as appropriate. At facility level there is an up to date hazard register. All hazards are prioritised, evaluated, monitored and reported against by the health and safety committee as confirmed during ten of ten staff interviews and confirmed in meeting minutes sighted. Staff verbalise a very good understanding of the hazard process. Two areas identified for improvement in the previous audit and are now fully attained.

Quality improvement data is collected, analysed and evaluated but not all information is shared with staff. No documented corrective action plans could be located on the day of audit. Both these areas are identified for improvement.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:
Timeframe (days): <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.

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

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

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

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

Attainment and Risk: PA Low
Evidence: Quality improvement data is collected, analysed and evaluated. Information sighted includes benchmarking data for infection control, restraint, falls with and without injury, staff injuries, complaints and restraint use. The benchmarked data results are then sent back to the facility from head office in graph form. During interviews with ten of ten staff they report that they are not aware of this benchmarked information but that they are made aware of the monthly data that is collected.
Finding: Whilst monthly data is shared with staff no evidence could be found that benchmarked data is shared with staff. This does not allow staff to be informed of how each month compares with previously collected data.
Corrective Action: Ensure all quality and improvement data is shared with service providers.
Timeframe (days): 180 (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 Low
Evidence: Staff meeting minutes identify some corrective actions that have been put in place. Audit reports also indicate that corrective actions have been put in place when a deficit is found. However on the day of audit no corrective action plan forms could be located. The village manager stated during interview that the forms have been completed but did not know where to locate them as they are completed by the nurse manager who is away on holiday.
Finding: No documented corrective action forms or quality improvements could be located on the day of audit.
Corrective Action: Ensure corrective actions plans are completed and available to staff to show how deficits found have been addressed and what outcomes or improvements have been achieved.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The village manager and organisational representative (clinical quality and risk manager) confirm required reporting standards are clearly identified in policy. Policy identifies the statutory and regulatory obligations of the service in relation to essential notification reporting to the correct authority.

A review of five of five resident files (four hospital and one rest home level) identifies that accident and incident forms are used to report all issues. The incident and accident forms identify if a corrective action is required. Family/whanau notification is clearly shown. Interviews with two of two family/whanau confirm they are always informed of any adverse events or issues that arise.

Incidents and accidents and related data are discussed at senior management level at the monthly 'SMT' meeting. This is confirmed in meeting minutes and during discussion with the organisation's director of nursing. Incident and accident data is benchmarked among all Metlifecare facilities. This data identifies that of nine care facilities Metlifecare Highlands statistics sit around the median mark.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: <p>Professional qualifications are validated prior to employment and on an ongoing basis. Annual practising certificates are sighted for 10 RNs including the nurse manager, three GPs, the podiatrist, four pharmacists, and one physiotherapist.</p> <p>Processes are in place at organisational and facility level to ensure the appointment of appropriate service providers to safely meet the needs of residents.</p> <p>A review of ten of ten staff files (nurse manager, one senior RN, one newly appointed RN, the activities coordinator, the maintenance supervisor, one kitchen hand, one domestic aid, one laundry assistant and two caregivers) identifies that good employment processes are implemented at Metlifecare Highlands Hospital. Two files that do not contain completed orientation belong to staff that have worked at the facility for many years.</p> <p>Staff undertake education as part of their orientation process which allows them to deliver services to meet residents' needs. Ongoing education both onsite and offsite occurs to meet identified staff needs and interests. This is confirmed during interview with ten of ten staff.</p> <p>The in-service education calendar shows what education is to be put in place to meet organisational requirements. Not all required education is signed off as being delivered at Metlifecare Highlands Hospital and the content of the education delivered could not be located on the day of audit. This is an area identified for improvement.</p>

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

Attainment and Risk: PA Low
Evidence: Required education is shown on an annual calendar. The educational calendar sighted for 2013 and 2014 covers all aspects of service delivery. Guest speaker educational content was available in the education folder but the in-service education content could not be verified for education delivered by the nurse manager as the file could not be located on the day of audit. The educational calendars sighted did not have signoff against all documented education.
Finding: 1. Documentation sighted to say education related to informed consent (1.1.10.2) and advocacy (1.1.11.1) has been undertaken but no specific information could be found on the day of audit. No education content or staff attendance numbers could be found. Corrective action planning states all the information was provided to the District Health Board related to the previous audits identified improvements but the information could not be located. 2. Documentation identifies that abuse and/or neglect education was offered on the 22 August 2013 and 17 staff attended. No content of the education could be located. This is related to criterion 1.1.3.7 (also refer to comment in standard 3.4). 3. No evidence could be found to show that all documented education shown on the calendar was undertaken and only guest speaker content of educational sessions delivered could be located on the day of audit.
Corrective Action: Ensure all planned education is accurately recorded and supported by content material to show what was delivered.
Timeframe (days): 180 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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:

A review of the rosters identifies that staffing numbers and skill mix is implemented to meet Metlifecare organisational requirements using a ratio that has been approved at executive level. All shifts are covered by RN's and as per policy requirements, all clinical staff undertake first aid training. This is confirmed in the staff file reviews.

Additional staff are rostered on duty according to resident needs and acuity levels. This is confirmed by clinical staff interviews. One newly appointed RN stated that she felt she was asked to perform tasks above her skill level owing to being short staffed. This was followed up on the day of audit and rosters sighted evidence that an additional RN was put on duty as soon as the nurse manager was made aware of this situation.

All staff report they have time to complete required tasks within rostered hours.

Interviews with five of five residents and two of two family/whanau members confirm they are happy with standard of service provided.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Service delivery documentation is overseen by the RNs. Documentation is part of the audit process and reviewed at regular intervals to ensure documentation is completed within required timeframes. In the five files reviewed (four hospital and one rest home) there is evidence of initial assessments and care plans being completed and clinical risk tools being reviewed within the required timeframes.

Highlands Hospital has not yet commenced using interRAI computer programme for assessments but two RNs are in the process of completing the training. The long term care plan template is personalised, reviewed and amended within required timeframes. The clinical risk assessments and follow up times for documentation reviews are all completed.

The RNs report there is a process for annual multidisciplinary resident reviews, or earlier review if required. There is evidence in the five files (four hospital and one rest home) reviewed that the family/whanau are involved in any care changes and reviews. Handover at the beginning of each shift is undertaken in the nurses' station for privacy. Highlands Hospital have the services of GP's at the local surgery who visit twice weekly or at other times if required. The GP's share on call 2 hours a day and seven day a week (24/7) cover for all residents.

The two RNs report that Community Geriatric Services from the Counties Manukau District Health Board (CMDHB) visit as required and a referral is made to a dietitian for unexplained weight loss.

The two relatives interviewed are very positive about the staff, GP and all aspects of care. The five clinical staff interviewed (two RN, three caregivers) report that they are kept up to date with all clinical changes.

Tracer Methodology Hospital Level Care:

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

Tracer Methodology Rest Home Level Care:

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

ARRC requirements are met.

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

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

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

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

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

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

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

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

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

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: <p>In the five files reviewed (four hospital and one rest home level) there is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are evaluated at required timeframes to ensure residents' desired outcomes are being met. A specific example is a resident who required bedrails while in bed due to a falls risk. All documentation is completed including consent, evaluation and monitoring requirements.</p> <p>The five clinical staff interviewed (two RN's and three caregivers) report they are informed of any care plan changes at hand over and have relevant in-service education as required.</p> <p>ARRC requirements are met.</p>

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is one activities coordinator who works a total of 40 hours each a week employed at Highlands Hospital. The activity coordinator has completed her diversional therapy qualification and NZQA dementia standards. Activities are available for all residents over seven days as the caregivers undertake activities during the hours when the activity coordinator is not on site. Care staff report that they undertake activities with residents particularly in the weekend.</p> <p>The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents. During interview the activity coordinator reports that it is important to have activities at similar times as the residents appreciated the routine. This is particularly important for bingo as this is well attended. Physical activities are best in the morning as this is the residents' more alert times, and just before lunch the coordinator reports she has a music to stimulate the residents' appetites prior to lunch.</p> <p>External visits for the residents include the RSA for lunch, beach trips and to the cathedral or special services. Schools in the community attend the facility to undertake community service weekly as a part of their curriculum. The two relatives report on interview the activities are positive and include walking and music.</p> <p>ARRC 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.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Individual short term care plans are seen for wound care, infections and weight loss. These are kept in the resident's folder and each shift documentation is made in the file. Evidence is seen of sign off when completed or transferred to the long term care plan as required.</p> <p>Long-term care plans are reviewed every six months or earlier as required. Evidence of this was sighted in the five files reviewed. Progress notes are signed each duty by RN. Evidence is seen of the family/whanau involvement in the care reviews. In all five files reviewed evidence is seen of documentation if an event occurs that is different from expected and requires changes to service.</p> <p>There is a separate page to document when a family member has been contacted and the two relatives report that they are given the opportunity to be involved in all aspects of care and reviews.</p> <p>The five clinical staff interviewed have knowledge of the care plan documentation requirements.</p> <p>ARRC 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.

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Highlands Hospital uses blister pack medicine system whereby medicines are delivered weekly except for PRN (as required) medication which are delivered as required. When the blister pack medicines are delivered they are checked by the RN and evidence is seen of the signing sheet. There are controlled drugs on the premises and all processes comply with the legislative requirements.

There is evidence in all ten files reviewed (eight hospital and two rest home) that medication charts are reviewed three monthly by the GP.

Standing orders are used at this facility and they are current and comply with current requirements.

Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The RN reported that the GP works with the pharmacy but he/she is responsible for all medicines administered to his residents. If medicine is brought in by family this is approved by the GP and he/she charts on the medication sheet.

The RNs are responsible for all medication rounds. Evidence is seen of the designated staff having up to date competency for medicine management and administering medicines.

There is no self-administration of medicines at Highlands Hospital.

Medicine sheets are signed in ink as required following administration.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
<p>Highlands Hospital operates a seasonal menu cycle approved by a dietitian (sighted). The consultant dietician reviews the menu every six months and comments on the nutritional content of the menu. The previous corrective action has been completed.</p> <p>An individual dietary assessment is completed on admission which identifies individual needs and preferences. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans.</p> <p>The service is managed by a kitchen manager who is a qualified chef and has been employed by the company for five years. Evidence is sighted of meal planning, cleaning routine and audit requirements being completed. There are two chefs who work over seven days. Both are to update with their food safety certificates. Evidence is seen of attendance at annual updates on infection control and first aid. The chef reports on interview that he is supported by management on food supplies and understands the individual requirements of the residents. Evidence is seen of resident surveys and if any concerns are expressed relating to meals the chef attends residents meetings to discuss the concern.</p> <p>If residents require assistance with feeding a caregiver is available to assist.</p> <p>ARRC requirements are met.</p>

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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 service has a current building warrant of fitness that expires on 5 March 2015. There have been no changes to the building footprint since the previous audit. There is documented evidence that long term maintenance is undertaken as required. This was an area identified for improvement in the previous audit and is now fully attained.

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.)

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Policy clearly identifies the use of enablers is voluntary and that the least restrictive option is used to meet the needs of the resident. Enablers are used to promote or maintain resident independence and safety. The service has no enablers in use at the time of audit. There are two restraints in use, one chair lap belt and one bedside rail. All processes are clearly documented and the restraint register is up to date. The service is able to demonstrate that the use of restraint is actively minimised and the restraint register identifies when restraint is no longer required.

Interviews with two RNs and three caregivers identify their knowledge and understanding of restraint use and the difference between restraint and enablers.

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

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

Attainment and Risk: FA

Evidence:

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

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

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
<p>Evidence:</p> <p>In the case of an outbreak, advice will be sought from the GP, laboratory services and experts at the CMDHB. The IPCC/RN is responsible for gaining infection control/infectious disease/microbiological advice and support, where this is not available within the organisation. The facility had an outbreak in June 2013 and evidence is seen of the correct procedures followed and documentation completed.</p> <p>Education is also provided by the infection control nurse at CMDHB and staff are given the opportunity to attend these in-service education sessions. The ten staff interviewed report good knowledge of infection control, standard precautions and outbreak management. The five residents and two relatives report they are informed of any infections and notices are put on the door when required.</p> <p>There is documented evidence of the annual education to be undertaken by the infection control nurse and this meets mandatory requirements. The previous corrective action has been completed. ARRC requirements are met.</p>

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

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

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

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: PA Low
Evidence: <p>Staff orientation covers infection control education relevant to practice within the organisation. Infection prevention and control education was provided to all staff in 2013. Ten staff interviewed confirm attending these in-service educations. The education plan for 2014 is sighted and includes infection control sessions.</p> <p>Education is provided to residents (and/or family members) related to hand hygiene and isolation, if there is an infection outbreak. This is confirmed in interview with residents and families members.</p> <p>Evidence is sighted of the infection control education being evaluated to ensure content is pertinent to this aged care setting. The previous corrective action has been completed.</p> <p>The infection control nurse is not maintaining formally a record of the content of the infection education provided to staff. The previous corrective action has not yet been met.</p>

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

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

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

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

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

Attainment and Risk: PA Low
Evidence: Evidence is not seen of the infection control nurse maintaining a formal record of the content of the infection education provided to staff.
Finding: The infection control nurse is not maintaining formally a record of the content of the infection education provided to staff. The previous corrective action has not been met.
Corrective Action: Ensure the content of all education related to infection prevention and control is documented.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: FA

Evidence:

The type and frequency of surveillance is clearly stated in policy and is appropriate to the complexity of the organisation. Surveillance methods, analyses and responsibilities are clearly described within the infection control policy. Policy states that surveillance data/information will be presented at staff meetings. An annual summary of the number and type of infections per month is maintained and sighted for 2013.

A register is kept of all residents who develop infections, the type of infections, results of cultures (where obtained) and details of treatment provided. The register notes whether further follow-up is required. The data is entered into the computer each month and reports of surveillance data is presented at monthly staff meetings. The data is benchmarked against other company facilities within the group monthly.

Evidence is sighted of surveillance data from the initial completion of the infection notification form and the process that this becomes part of the quality system. Staff report they are notified of any infections at handover and families are contacted as required.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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