

Metlifecare Limited - Somervale

Current Status: 27 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

Metlifecare Somervale is owned and operated by Metlifecare Limited. It offers hospital and rest home level care for up to 40 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.

On the day of audit 35 beds are occupied consisting of 30 hospital level and five rest home level care residents. There have been no changes made to the facility or services since the last audit.

Two areas identified as requiring improvement in the previous audit are now fully attained. One new area requiring improvement is identified relating to residents' self-administration of medication. The requirements of the facility's agreement with the district health board are met.

Audit Summary as at 27 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 |
| | 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 27 May 2014

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Organisational Management as at 27 May 2014

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |
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Continuum of Service Delivery as at 27 May 2014

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of low risk. |
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Safe and Appropriate Environment as at 27 May 2014

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Standards applicable to this service fully attained. |
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Restraint Minimisation and Safe Practice as at 27 May 2014

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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Infection Prevention and Control as at 27 May 2014

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| <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 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

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| Legal entity name: | Metlifecare Limited |
| Certificate name: | Metlifecare Limited - Somervale |
| Designated Auditing Agency: | The DAA Group Limited |
| Types of audit: | Surveillance Audit |
| Premises audited: | Metlifecare Somervale |
| Services audited: | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 27 May 2014 End date: 27 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: | 35 |

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 | 4 | Number of staff interviewed | 11 | Number of managers interviewed | 2 |
| Number of residents' records reviewed | 4 | Number of staff records reviewed | 10 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 8 | Total number of staff (headcount) | 40 | Number of relatives interviewed | 3 |
| 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 Tuesday, 10 June 2014

Executive Summary of Audit

General Overview

Metlifecare Somervale is owned and operated by Metlifecare Limited. It offers hospital and rest home level care for up to 40 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. On the day of audit 35 beds are occupied consisting of 30 hospital level and five rest home level care residents. There have been no changes made to the facility or services since the last audit.

Two areas identified as requiring improvement in the previous audit are now fully attained. One new area requiring improvement is identified relating to residents' self-administration of medication. The requirements of the facility's agreement with the district health board are met.

Outcome 1.1: Consumer Rights

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. Residents state 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. Information is shared in a manner that is reflective of open disclosure principles.

The organisation respects and supports the right of the resident to make a complaint. Complaints management is undertaken to meet policy requirements which include information being recorded electronically in the organisation's electronic reporting system. The complaints register is up to date and identifies that there is one open complaint not of a serious nature.

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 clinical manager who is supported by the village manager. At the time of audit the clinical quality and risk manager from head office is undertaking the clinical manager role. A newly appointed clinical manager has yet to commence in the role.

The service has a well-established quality and risk management system which is understood and implemented by staff. Key components of service are reported at service level monthly and at organisational level quarterly against key performance indicators as identified in the business plan. Quality data results, including any corrective actions that may be required, are shared with staff and management. Corrective action planning is used to improve service delivery where appropriate.

Resident and family/whanau interviews confirm they are kept informed of any adverse events and that they are happy with the level of care and services provided. This is supported by documentation sighted including incident and accident forms. The area identified for improvement in the previous audit is now

fully attained.

Human resources management processes are 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.

The service implements staffing levels and skill mixes that meet contractual requirements as identified in policy and confirmed in a review of 2014 staffing rosters.

An area identified as requiring improvement in the previous audit related to the storage of health information is now fully attained.

Outcome 1.3: Continuum of Service Delivery

The provision of services is delivered by suitably qualified and experienced staff.

The provision of care is based on the assessed needs of the resident, for residents at either rest home or hospital level of care, and is provided in time frames that meet the resident's needs and contractual requirements. The lifestyle care plans reflect the needs of the residents and describe the interventions required to achieve the resident's goals. The lifestyle care plans are evaluated at least five monthly to ensure the residents are progressing towards meeting their desired goals. When the needs of the residents change, the lifestyle care plans are updated or short term care plans are used to reflect the changed needs.

The activities are planned to meet the needs and strengths of the residents.

The menu is reviewed by a dietitian as suitable for the older person living in a care facility.

A safe medicine administration and storage system is observed on the day of audit. Staff who are responsible for medicine management are assessed as competent to perform the role. There is one area requiring improvement to ensure the organisation's policies and procedures are followed for residents who self-administer their own medicines.

Outcome 1.4: Safe and Appropriate Environment

The service has an up to date building warrant of fitness. There have been no changes to the building footprint since the previous audit.

Outcome 2: Restraint Minimisation and Safe Practice

Policy identifies 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 one enabler and one restraint in place. All processes have been appropriately completed to meet policy and legislative requirements.

Outcome 3: Infection Prevention and Control

The service has an appropriate system for the surveillance of infections, which reflects the size and scope of the service. Where the infection rates are higher than expected the service implements a risk management plan to address any shortfalls identified.

Summary of Attainment

| | CI | FA | PA Negligible | PA Low | PA Moderate | PA High | PA Critical |
|------------------|----|----|---------------|--------|-------------|---------|-------------|
| Standards | 0 | 16 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 0 | 39 | 0 | 0 | 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 | 33 |
| Criteria | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 61 |

Corrective Action Requests (CAR) Report

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|--------------------------------------|---|-------------|--|--|------------------|
| 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 Low | | | |
| HDS(C)S.2008 | Criterion 1.3.12.5 | The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | The organisational procedure for facilitation of safe self-administration of medicines is not signed for the one resident who self-administers one of their medicines. | Ensure the organisational procedures for the facilitation of self-administering of medicines are followed and evidenced. | 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; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

Policy identifies that residents have a right to full and frank information. The principles of open disclosure are embedded into everyday practice. Management operate an open door policy and any concerns or incidents are discussed with family/whanau as appropriate. This is confirmed during interviews with four of four residents (one rest home and three hospital level) and three of three family/whanau members.

Access to interpreter services, as documented in the staff room, regular residents' meetings and multidisciplinary clinical reviews (which included family/whanau members), provides an environment conducive to effective communication. The service operates a computer 'quick-link' to resident rights in all languages. The 2013 resident satisfaction survey rated 97.3% for overall satisfaction results.

Interviews with 11 of 11 staff (the cook, two domestic aids, three caregivers, one diversional therapist, three registered nurses and the administrator) confirm their knowledge and understanding of open communication processes. Each of the four resident file reviews contains a family/whanau communication sheet which is used to document family/whanau contact. A 'per shift' clinical handover occurs to ensure staff are kept fully informed of each resident's needs.

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:

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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| Attainment and Risk: FA |
| Evidence: |
| 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

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| Attainment and Risk: FA |
| Evidence: Metlifecare Somervale implements organisational policy related to complaints management. Policy identifies that the service has a fair and responsive process in place. Interviews with four of four residents and three of three family/whanau members confirms the complaints process was explained to them and they can access complaints forms in the main foyer at any time. 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. At the time of audit there is one open complaint that is not of a serious nature. |

The portfolio manager from Bay of Plenty District Health Board had a query related to the services dispute resolution process. This was reviewed at the time of audit and all processes including family/whanau being informed are implemented by the service.

ARRC requirements are met.

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

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

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| 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.

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Metlifecare Somervale contributes to the organisational business plan via localised specific goals which are reported against quarterly. The organisational and local business plans are reviewed annually. The planning process identifies the values, scope, direction and goals of the organisation and Metlifecare Somervale at a local level.

Currently the facility is being managed by the clinical quality and risk manager registered nurse (RN) from head office for clinical care and the village manager, who has been in the role for over seven years. A new clinical manager has been appointed and is yet to commence the role. Both managers interviewed on the day of audit are skilled and experienced in aged care and ensure all services are planned and coordinated in a manner to meet resident needs.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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| 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

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| Attainment and Risk: FA |
| Evidence: <p>Metlifecare Somervale implements organisational quality and risk systems which include regular ongoing audits to identify areas where corrective actions may be required. Interviews with 11 of 11 staff from across all areas of service confirm they understand quality systems and implement corrective actions as required. This is supported in staff meeting minutes sighted and the results of planned audits which cover all aspects of service delivery.</p> <p>The audit schedule sighted identifies all audits are up to date and that corrective actions are put into place as appropriate. One example sighted shows that standing orders for medication management required updating this has been completed and signed off by management.</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 via computer and in hard copy. Staff are informed of policy updates and/or changes during staff meetings and via notices placed on the staff notice board.</p> <p>Key components of service delivery which include health and safety, infection control, restraint, complaints management and quality improvements are linked to the quality management systems. Data is shared with staff and management and regular monthly reporting is undertaken at a senior management level. Reporting is aligned with and contributes to the business planning process which includes quality and risk.</p> <p>Quality improvement data for all key components of service are collected, analysed and evaluated and used to identify opportunities for service improvement via corrective action planning. One example relates to the identification and appropriate corrective actions planned to reduce the number of skin tears.</p> |

Actual and potential risks related to all operations of the business are identified, documented and communicated to residents, family/whanau and staff as appropriate. Metlifecare Somervale have an up to date hazard register which identifies that hazards are prioritised, evaluated, monitored and reported against by the health and safety committee. This is confirmed in meeting minutes sighted.

ARRC requirements are met.

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

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

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| 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.

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| 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.

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| 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.

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| 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.

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| Attainment and Risk: FA |
| Evidence: |

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

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

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

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

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

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: |
| 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 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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

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

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| Attainment and Risk: FA |
| Evidence: <p>Metlifecare organisational policy identifies statutory and regulatory reporting obligations. This process is understood and implemented by Metlifecare Somervale management. One example sighted relates to a resident who had a fall resulting in a fracture. Completed notification forms are sighted.</p> <p>A review of four of four resident files (three 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 three of three family/whanau members confirm they are always informed of any adverse events or issues that arise. This was an area identified for improvement in the previous audit and is now fully attained.</p> <p>Meeting minutes identify that incidents and accidents and related data are discussed at staff and management meetings. Incident and accident data is benchmarked among all Metlifecare facilities. The results of the 2013 satisfaction survey identifies that 98% of family/whanau members are satisfied with information sharing.</p> <p>ARRC requirements are met.</p> |

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

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

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

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| 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: FA

Evidence:

Metlifecare organisational human resources management policies and procedures are implemented at Metlifecare Somervale. Staff qualifications are validated prior to employment and on an ongoing basis. Annual practising certificates are sighted for 10 RNs, 19 GPs, one occupational therapist and one pharmacist.

Processes are in place at organisational and facility level to ensure the appointment of appropriate service providers to safely meet the needs of residents. This is identified in job descriptions which clearly state each roles scope of practice.

A review of ten of ten staff files (nurse manager, two RNs, one diversional therapist, one cook, one cleaner one laundry worker and three caregivers) identifies that good employment processes are fully implemented at Metlifecare Somervale. This includes comprehensive orientation and induction processes which inform staff orientation sign-off books. Interviews with 11 of 11 staff from across the service confirm the orientation process ensures services can be delivered in a manner to meet all residents' needs.

The in-service education calendar and training content sighted identifies that staff are able to offer safe and effective care to residents.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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| 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.

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| Attainment and Risk: FA |
| Evidence: |

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

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

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

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| Attainment and Risk: FA |
| <p>Evidence:</p> <p>Metlifecare has an organisational policy related to staff skill mix and experience to reflect resident needs are met in a timely, appropriate and safe manner. A review of the Metlifecare Somervale rosters for five months (all of 2014) identifies that staffing numbers and skill mix is implemented to meet policy requirements. All shifts are covered by RNs and staff who hold first aid qualifications. This is confirmed in documentation sighted and during interview with three of three RNs and three of three caregivers. The sample of rosters was extended as on staff member stated that sick leave was not covered. The roster review clearly shows this not to be the case. All leave is covered. This is confirmed by the acting clinical manager and the village manager.</p> <p>Staff report during interview that they have time to complete required tasks within rostered hours.</p> <p>Interviews with four of four residents and three of three family/whanau members confirm they are happy with standard of service provided.</p> <p>ARRC requirements are met.</p> |

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

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

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

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| 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 1.2.9: 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

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| Attainment and Risk: FA |
| Evidence: An area identified for improvement from the previous audit related to the management of documents is now fully attained by the service. The archiving system has been re-organised and policies and procedures have been reviewed and updated in relation to how archived documents are filed and stored. On the day of audit the administrator was able to retrieve an archived document quickly and accurately. |

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

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

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| 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 1.3: 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; D16.5cj; 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:

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced staff competent to perform the function. The RNs conduct the nursing assessment, lifestyle care planning, review and evaluation of the resident's care in consultation with the resident and where appropriate family/whanau and the multi-disciplinary team (MDT) of the GP, physiotherapist, diversional therapist and caregivers. The GP conducts the medical assessment and medical reviews. The caregivers provide most of the direct resident personal care. The care staff have access to ongoing education and national qualifications in the care of the older person. Annual practising certificates are sighted for all staff and contracted staff that require them. The GP interviewed reports a high level of satisfaction in the key nursing staff. The results from the resident and relative satisfaction surveys report high satisfaction with the care and services provided at Somervale.

The service has two RN trained in interRAI, with one of these RNs is provided with dedicated time to complete the electronic assessments. There are approximately 15 residents with the completed interRAI assessment. The service uses the interRAI assessment in conjunction with the Metlifecare paper based assessment tools. The RN reports that they ensure the triggers that are generated from the interRAI assessment are identified as issues on the lifestyle care plan. The current paper based initial assessments include personal support needs, communication, diet, fluids, culture, spirituality, sexuality, mobility, pain relief, cognition, continence, skin and wound. The initial assessments tools (paper based) also include pressure area risk; falls risk assessment, pain assessment, continence management assessment, dietary requirements, activities assessment, diversional therapy assessment, physiotherapy assessment and an occupational therapy assessment. There is an initial lifestyle care plan used for up to three weeks until the long term lifestyle care plan is developed. The paper based assessments are reviewed three monthly, the interRAI assessments are reviewed at least six monthly and the long term lifestyle care plans are evaluated at least five monthly, as confirmed in the four of four residents' files reviewed (one rest home and three hospital). There is an annual family meeting or MDT review that is formally conducted, though the RN reports that there is daily input from the multidisciplinary team (as evidenced in the four of four files reviewed).

The service utilises a standardised long term lifestyle care plan which is individualised to the resident's needs, their own individual long term lifestyle care plan for other identified needs and short term care plan for temporary changes. The long term lifestyle care plan identifies the need, goal, care requirements and clinical interventions. The needs identified on the long term lifestyle care plan include the needs identified during the assessment process. The long-term lifestyle care plans (lifestyle plan, diversional therapy plan, physiotherapy plan and occupational therapy plan) cover the physical, psycho-social, spiritual and cultural needs of the resident. Short term lifestyle care plans identify the problem objective, intervention, evaluation of the issue. The long term lifestyle care plans record those who are consulted to contribute to the lifestyle care planning (eg, resident, family, staff, key worker, diversional therapist, occupational therapist and physiotherapist). The four of four residents' files reviewed have the appropriate assessments, lifestyle care plans and desired goals identified.

The residents are reviewed by a general practitioner (GP) at least monthly, or three monthly when the resident is assessed as stable. All four resident files reviewed (one rest home and four hospital) record the initial review by the GP within two working days where appropriate. The four of four residents interviewed (one rest home and three hospital), report a high level of satisfaction with the medical coverage and feel they are able to access the GP when they require.

Each resident has one file which includes the multidisciplinary team input into care, any electronic record summaries are printed and a copy is placed in the resident's file. The progress notes record the daily care and input from the MDT. There is a verbal handover between each shift. The three of three RNs and three caregivers report that there is an adequate handover to provide information for the continuity of care and report an excellent team approach to care.

Tracer example one – rest home level of care.

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

Tracer example two: - hospital level of care.

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

The four of four residents and three of three family/whanau interviewed report high satisfaction with the care provided at the service.

The 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.

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| 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.

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

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has adequate dressing and continence supplies to meet the needs of the residents. The four of four lifestyle care plans reviewed (one rest home and three hospital), record interventions that are consistent with the residents' assessed needs and desired goals. Observations on the day of audit indicate residents are receiving care that is consistent with the residents' needs. The four of four residents and three of three family/whanau interviewed report that the service meets the needs of the residents. The four of four residents and three of three family/whanau interviewed have high praise for the interventions at the service.

The ARRC 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.

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| 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

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| Attainment and Risk: FA |
| Evidence: <p>The diversional therapist reports activities plans are individualised to the resident's needs. The activities are individualised and developed in conjunction with the resident and where appropriate their family. The activities/diversional assessments are used to develop a diversional therapy plan that is individualised to each resident, as sighted in the four of four residents' files reviewed. The activities/diversional assessment includes social pursuits, intellectual interests, creative pursuits, physical activity, and outdoor interests. The goals are updated and evaluated in each resident's file at least five monthly with lifestyle care plan reviews. The diversional therapist reports where residents have a specific need, the service endeavours to provide the resources for this. The diversional therapist reports that they assess and gauge resident's response during activities, and modify the programme based on the resident's needs.</p> <p>A monthly activities plan (sighted) is developed based on the resident's needs, interests, skill and strengths. The activities cover cognitive, physical and social needs. Where possible residents' independence is encouraged to maintain links with family and community groups. Residents are provided with outings on a routine basis. One to one activities are planned to meet the resident's interests. The facility is located next to a church and a number of residents independently attend this. The facility also has religious services and communion at the care facility.</p> <p>The four of four residents interviewed report they enjoy the range and variety of planned activities.</p> <p>The 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.

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| 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

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| Attainment and Risk: FA |
| Evidence: <p>The four of four lifestyle care plans reviewed evidence that evaluations are recorded at least five monthly. The documented evaluations indicate the resident's progress in meeting goals, and lifestyle care plans are updated to reflect progress towards meeting goals (confirmed in the four of four residents' files reviewed).</p> <p>Where progress is different from expected the service either updates the long term lifestyle care plan or uses short term lifestyle care plans for temporary changes. The four of four residents' files reviewed, (one rest home and three hospital), indicate they are updated to reflect the changing needs of the resident. The four of four residents and three of three family/whanau interviewed report involvement in the evaluation process and are satisfied with the care provided.</p> <p>The 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.

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| 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.

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| 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: PA Low

Evidence:

Medicines for residents are received from the pharmacy in the blister pack delivery system. The signing sheet that records the packs are checked for accuracy against the resident's medicine chart. A medicine reconciliation process occurs with new admissions and when the resident has been to a specialist or hospital admission. A safe system for medicine management is observed on the day of audit.

Medicines are stored in locked medicine trolleys and in the locked treatment room. There is a monthly stock rotation for the medicines that are not packed. The controlled drugs are stored in a locked cupboard, two staff sign the register at each administration and a weekly stock count is undertaken. There is an additional quantity stock count that is conducted at the end of each page in the controlled drug register. The service's medicine fridge is monitored daily and when the temperature varies from the recommended guidelines, the thermostat in the medicine fridge is adjusted.

Seven of the eight medicine charts reviewed are reviewed by the GP in the last three months; this is recorded on the medicine charts. One of the medicine charts has the last recorded GP review in October 2013; the medicine review is recorded in the resident's medical progress notes in January and April 2014 (the GP signed the reviews on the medicine chart on the day of audit). This reflects a one off incident and is not reflective of a systemic issue.

All prescriptions sighted contain the date, medicine name, dose and time of administration with any allergies recorded. All medicine charts reviewed have each medicine individually prescribed and signed by the GP. All signing sheets are fully completed on the administration of medicines for the past four weeks. The standing orders comply with legislation and are last reviewed by the GPs in May 2014.

There are documented competencies sighted for the staff designated as responsible for medicine management.

The RN reports that there is one resident assessed as competent to self-administer one of their medicines. The organisational policy documents that residents who self-administer medicines require the 'assessment of self-medication' to be completed by the RN and re-assessed three monthly. This assessment is not sighted in the resident's file.

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: FA

Evidence:

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| 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.

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| 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.

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| Attainment and Risk: PA Moderate |
| Evidence: There is one resident who self-administers one of their medicines. The lifestyle care plan that was last updated in April 2014 records that the resident self-administers this medicine. The organisation requires an assessment of self-administration and the resident's ability to self-administer their medicines assessed three monthly. This is not evidenced in the resident's file reviewed. The resident interviewed demonstrated knowledge and understanding of the medicine they self-administer (insulin). |
| Finding: The organisational procedure for facilitation of safe self-administration of medicines is not signed for the one resident who self-administers one of their medicines. |
| Corrective Action: Ensure the organisational procedures for the facilitation of self-administering of medicines are followed and evidenced. |

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.13: 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:

The 12 week rotating menu, with seasonal variations, is approved by a registered dietitian in March 2014 as suitable for aged care residents. A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets. Residents who have additional or modified nutritional requirements or special diets have these needs met, for example, the service provides diabetic, allergies and texture modified diets to meet specific residents' needs.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. It is noted that there was one bag of carrots on the floor in the chiller, with the kitchen staff reporting that this is a recent delivery. All other foods stored are off the floor in storage containers or on the shelves. Fridge and freezer recordings are undertaken twice daily and meet requirements. All foods sighted in the freezer and pantry are in their original packaging. The kitchen staff reports that there is a stock rotation when new supplies are delivered; these are placed towards the back of the shelf, with the current stored products being used before the newer deliveries. Staffs have undertaken food safety management education appropriate to service delivery.

The four of four residents and three of three family/whanau report satisfaction with the meal and drinks provided.

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

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

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

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| 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.

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| Attainment and Risk: FA |
| Evidence: |

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| 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

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| Attainment and Risk: FA |
| Evidence: Metlifecare Somervale has a current building warrant of fitness that expires on 20 September 2014. There have been no changes to the building footprint since the previous audit. |

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

All buildings, plant, and equipment comply with legislation.

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| Attainment and Risk: FA |
| Evidence: |
| 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:

Organisational restraint minimisation policy 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 one enabler and one restraint (both bedside rails) in use at the time of audit. 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 discontinued.

Interviews with three 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): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

Infection control data is collected on nosocomial infections which includes urinary tract infections (UTIs), skin infections, conjunctivitis, upper respiratory infections, oral and wound infections. The surveillance also includes a review of antibiotic treatments and multi-resistant organisms. The monthly data is collected and entered into the organisation's electronic system for ongoing follow up and analysis.

All care staff members are responsible for the reporting of suspected infections to the infection control co-ordinator. The infection control co-ordinator is responsible for ensuring appropriate action, notification and follow-up is undertaken. The data sighted for 2014 records an overall low rate of infections as compared with the benchmarking results with other Metlifecare facilities. The March 2014 data records that there were a total of five infections in the care facility, with two being UTIs. All residents with infections have been reviewed by the GP. The April 2014 surveillance data records a total of four infections, with no UTIs recorded and three upper respiratory tract infections. The respiratory tract infections are a reflection of community norms and seasonal variances.

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