

# Oceania Care Company Limited - Melrose Park

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Current Status: 5 June 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

Melrose Park is part of the Oceania Group. This surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Melrose Park provides residential hospital and rest home level care for up to 98 residents with 36 residents requiring hospital level care and 39 residents requiring rest home.

There is a business and care manager who has been in the role for 10 months. The service is recruiting into the position of clinical manager. Staffing is appropriate to support the needs of residents requiring hospital and rest home care.

All of the eleven improvements required from the certification audit have been completed as follows: collation of results from surveys, training records, documentation of medication recording charts, documentation of interventions, documentation of general practitioner review of medication, equipment checks, maintenance issues identified previously, hot water temperatures and fire and evacuation training.

Improvements are required to the following: documentation of short term care plans, documentation of administration of controlled medication, supervision of the medication trolley when administering medications and ongoing maintenance issues. Improvements continue to be required to maintenance of the building noting that these are new issues identified since the last audit.

## Audit Summary as at 5 June 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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

#### **Consumer Rights as at 5 June 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.		Standards applicable to this service fully attained.
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#### **Organisational Management as at 5 June 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.		Standards applicable to this service fully attained.
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#### **Continuum of Service Delivery as at 5 June 2014**

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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#### **Safe and Appropriate Environment as at 5 June 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.		Some standards applicable to this service partially attained and of low risk.
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## **Restraint Minimisation and Safe Practice as at 5 June 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 5 June 2014**

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## Introduction

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

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

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

## Audit Report

<b>Legal entity name:</b>	Oceania Care Company Limited
<b>Certificate name:</b>	Oceania Care Company Limited - Melrose Park
<b>Designated Auditing Agency:</b>	Health Audit (NZ) Limited
<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	Melrose Park Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 5 June 2014 <b>End date:</b> 6 June 2014

<b>Proposed changes to current services (if any):</b>

<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	44
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## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	4
<b>Other Auditors</b>	XXXXXX	<b>Total hours on site</b>	12	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2.5

## Sample Totals

Total audit hours on site	24	Total audit hours off site	10.5	Total audit hours	34.5
Number of residents interviewed	10	Number of staff interviewed	18	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	72	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

I, XXXXXX, Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health Audit (NZ) Limited	Yes
b)	Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health Audit (NZ) 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)	Health Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Thursday, 12 June 2014

# Executive Summary of Audit

## General Overview

Melrose Park is part of the Oceania Group. This surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Melrose Park provides residential hospital and rest home level care for up to 98 residents with 36 residents requiring hospital level care and 39 residents requiring rest home. The service is no longer providing dementia level care (now provided by the sister site).

There is a business and care manager who has been in the role for 10 months. The service is recruiting into the position of clinical manager. Staffing is appropriate to support the needs of residents requiring hospital and rest home care.

Eleven of the 11 improvements required at the certification audit have been completed as follows: collation of results from surveys, training records, documentation of medication recording charts, documentation of interventions, documentation of general practitioner review of medication, equipment checks, maintenance issues identified previously, hot water temperatures and fire and evacuation training.

Improvements are required to the following: documentation of short term care plans, documentation of administration of controlled medication, supervision of the medication trolley when administering medications and ongoing maintenance issues. Improvements continue to be required to maintenance of the building noting that these are new issues identified since the last audit.

## Outcome 1.1: Consumer Rights

Staff are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family and complaints are investigated. Staff communicate with residents and family members following any incident.

## Outcome 1.2: Organisational Management

Oceania has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office with input from managers across the services. Monthly business status reports allow monitoring of service delivery. Benchmarking reports are produced that include incidents/accidents, infections and complaints.

Staffing levels are adequate and interviews with residents and relatives demonstrate that they have adequate access to staff to support residents when needed. The service is currently recruiting into the clinical manager position and in the meantime the service is supported by the facility manager, clinical leader from a sister site and by the clinical and quality managers (both registered nurses).

Improvements required at the certification audit have been completed including collation of results from survey, documentation of mandatory training records and training for kitchen staff.

## Outcome 1.3: Continuum of Service Delivery

The service have suitably qualified and/or experienced service providers. The acting clinical manager is from an agency supported by the clinical leader from the sister organisation. The registered nurses admit new residents using standard assessment tools. Person centred care plans are developed within three weeks from admission and are reviewed six monthly. The short term care plans for acute infections are not consistently developed when required. The service uses an integration system in their documentation. Communication books are utilised among the staff. The contents of the observed hand-over are comprehensive and resident focused.

A medicines management system is not consistently implemented to manage safe and appropriate administration. The GP prescribes medications and medication charts are reviewed three monthly. All staff who administer medications have current medication competencies. Controlled drugs are locked inside a locked cupboard. There are no expired medications sighted. Fridge temperatures are monitored daily.

The resident's nutritional needs are met. Foods served are appropriate and meets the recognised guidelines for the elderly. The food is well-presented and the portion is adequate. The four week winter and summer menus were last reviewed by the dietician on March 2014. Dietary profiles are kept in the resident's files and in the kitchen file. Special diets are provided to the residents. Additional food supplements are also provided for the residents. Food temperatures are monitored each meal. Fridge, chiller and freezer temperatures are recorded daily. The kitchen manager is a trained chef and rotates the stock using the first in-first out system.

Activities are appropriate to the resident's needs, age, culture, and the setting of the service. An activities plan is integrated in the resident's person centred care plan. The recreational assessment forms the activities plan. Activities are reviewed six monthly.

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

There is a current building warrant of fitness in place. There is a preventative and reactive maintenance programme including equipment and electrical checks. Improvements required at the certification audit have been completed as follows: equipment checks, hot water temperatures and fire and evacuation training. Maintenance issues required at the previous audit have been completed. There continue to be ongoing maintenance issues identified as being required improvements.

#### **Outcome 2: Restraint Minimisation and Safe Practice**

There is currently no residents using an enabler. The staff demonstrate good knowledge about restraints and enablers. The restraint minimisation policies and procedures are implemented and the use of restraint is actively minimised by the service. The restraint training is last conducted on March 2014 where restraint and enablers is differentiated as sighted in the in-service education hand-out.

#### **Outcome 3: Infection Prevention and Control**

The surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have specified in the infection control programme. The type of surveillance is appropriate to the size and complexity of the service. Infection rates are monitored monthly and collated by the infection control coordinator. These infections are entered in the intranet system for benchmarking with other services within the organisation. Infection rates are discussed during staff meetings to prevent and manage infections in the facility.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	17	0	1	2	0	0
Criteria	0	42	0	1	2	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	30
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 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Moderate	<p>1. One out of four resident's wounds do not have wound assessments, wound care plans, evaluations or dressing change monitoring and there is no reference of this wound in the resident's progress notes.</p> <p>2. Two out of four residents with urinary tract infections (UTI) do not have short term care plans developed. The medical notes evidence that an antibiotics is prescribed for the two residents.</p>	<p>Short term care plans and wound care plans/evaluations must be developed for acute infections.</p>	30

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
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 Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	<p>The medication trolley is left unlocked by two health care assistants while administering medications in two out of two observed medication rounds (one at lunch time, one at dinner time).</p> <p>2. The documentation of administered controlled drugs is not consistently reflected in the controlled drugs register.</p>	<p>That staff will lock the medication trolleys when unattended.</p> <p>2. All staff to comply with the policies and procedures in relation to administration and documentation of controlled drugs.</p> <p>3. A system to be implemented to minimise errors in relation to administration and documentation of controlled drugs.</p> <p>4. That staff will demonstrate better knowledge in relation to documentation of administered controlled drugs.</p>	30
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>	<b>Corrective Action</b>	<b>Timeframe (Days)</b>
HDS(C)S.2008	Criterion 1.4.2.4	The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	There continues to be some peeling wallpaper since the last audit noting that bedrooms in wing one and two in the rest home have been refurbished along with some rooms in wings four and five. There is an ongoing maintenance and refurbishment programme in place that is continuing. There are two bathrooms and a cupboard with wall and floor damage. All are non-resident areas (confirmed by the business and care manager and the health care assistants interviewed). All issues related to maintenance are identified on the planned maintenance list.	Address issues related to maintenance in bathrooms and cupboards as planned.	180

## Continuous Improvement (CI) Report

<b>Code</b>	<b>Name</b>	<b>Description</b>	<b>Attainment</b>	<b>Finding</b>

# 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:

Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available.

Family are informed if the resident has an incident, accident, has a change in health or a change in needs, evidenced in 15 of 15 completed accident/incident forms and in the resident files.

Family contact is recorded in residents' files – sighted in six of six resident files reviewed.

Interviews with five family members (two hospital and three rest home) confirm they are kept informed. Family also confirm that they are invited at least six monthly to the care planning meetings for their family member.

Family interviewed confirm that they are invited to attend the resident meetings.

Interpreter services are available when required from the District Health Board. There are no residents currently requiring interpreting services.

The information pack is available in large print and advised that this can be read to residents.

Staff have had training around communication in March 2014.

The District Health Board contract requirements are met.

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

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

#### Attainment and Risk: FA

##### Evidence:

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

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

#### **Standard 1.1.13: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
The organisation's complaints policy and procedures is in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes time-frames for responding to a complaint. Complaint's forms are available at the entrance of the rest home and hospital. There is also a 'mail' box and anyone can put a note in the box with follow up according to the complaints policy.
A complaints register is in place and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint's folder.
Two complaints selected for review that have been entered in 2014 show that time-frames are met for responding to these complaints with documentation indicating that the complainants are happy with the outcome.
Ten of 10 residents (six rest home including one resident using respite services) and five family members (three rest home and two hospital) state that they would feel

comfortable complaining. One family member states that a complaint had been made and this has been addressed through the care plan review. The business and care manager states that there have been no complaints with the Health and Disability Commission since the last audit or with other authorities. The District Health Board contract requirements are met.

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

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

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

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

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

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

## 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:**

Melrose Park is part of the Oceania group with the executive management team including the chief executive officer, general manager, operations manager, regional operational managers and clinical and quality managers providing support to the service.

Communication between the service and managers takes place on a monthly basis with more support being provided recently since the departure of the clinical manager (confirmed by the quality and clinical manager interviewed).

Oceania has a clear mission, values and goals. The vision is to be the provider of choice for senior New Zealanders of care and lifestyle options in a way that meets and exceeds the expectations of our residents, staff and stakeholders. The mission is 'we provide excellent contemporary care that reflects our residents' individuality and their right to choice, respect and dignity. We provide a positive and welcoming environment in which our residents are encouraged and supported to improve their quality of life'.

The facility can provide care for up to 98 residents requiring hospital or rest home level of care. The service no longer has a dementia unit. During the audit there are 75 residents living at the facility including 39 residents at rest home level of care and 36 residents at hospital level of care.

The business and care manager is responsible for the overall management of the facility. The business and care manager has been in the role for 10 months and an email confirms that HealthCERT has been notified of the appointment. The business and care manager has a background as an auditor of health services and has a post graduate certificate in health management.

The business and care manager is supported by the clinical and quality managers.

The acting clinical manager is a registered nurse from the bureau who has a further four weeks contract while the recruitment process is taking place. The clinical manager has extensive overseas experience in England in medical service nursing including wound management and chronic care. The acting clinical manager has a New Zealand practicing certificate that is current.

The District Health Board contract 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:**

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
Melrose Park uses the Oceania quality and risk management framework that is documented to guide practice. The business plan is documented and reported on through the business status reports. This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incidents, relationships and market presence action plan and review of physical products. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy at the nurses stations and in the business and care managers office. New and revised policies are presented to staff to read and staff sign to say that they have read and understood – sighted and confirmed by the four health care

assistants interviewed.

All staff interviewed including four of four health care assistants, the activities coordinator, the maintenance staff, the clinical leader from a sister service who is supporting Melrose Park currently, the acting clinical manager, the cook and two registered nurses report they are kept informed of quality improvements.

The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures, and a health and safety plan are in place for the service. There is a hazard management programme documented 2013-14 with a hazard register for each part of the service. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated.

The organisation holds a current ACC Work Safety and Management Practice tertiary level accreditation.

There is a Community Connect newsletter from the organisation.

An improvement relating to collating results from resident/family satisfaction surveys and acting on any recommendations required at the certification audit has been addressed. A collated report from the October 2013 survey indicates that residents and family are satisfied overall with the service and the quality and risk meeting minutes in 2013 evidence progression of analysis of results. The April/May 2014 satisfaction survey has just been collated and the business and care manager states that the report will be tabled at the next quality and risk and management meetings.

Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, implementation of an internal audit programme noting that improvements identified as being required have a corrective action plan documented and evidence of resolution of issues documented in meeting minutes particularly in the quality and risk meeting minutes and other meeting minutes when these are documented.

There are meetings held across the service including monthly quality and risk meetings, health and safety, resident/family, registered nurse, housekeeper, management (including the business and care manager and the heads of department at the site and including the clinical leader from the sister service) and health care assistant meetings. There are three monthly restraint meetings. The business and care manager has started documenting minutes of the full staff meeting (May 2014 sighted) noting that attendance records have been kept for 2013 and 2014.a

The District Health Board contract 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Criterion 1.2.3.8 (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.

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

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

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

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
The business and care manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There are no times since the last audit when authorities have had to be notified. There have been no outbreaks since the last audit.
The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the business and care manager and clinical and quality manager.
Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.
Fifteen incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event.
Information gathered is regularly shared at the monthly management meeting and regional meetings with the business and care manager documenting incidents which are then graphed, trends analysed and benchmarking of data occurring with other Oceania facilities.
The District Health Board contract requirements are met.

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

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

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

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

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

#### **Standard 1.2.7: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
All registered nurses, the clinical leader and the business and care manager hold current annual practising certificates. Visiting practitioner's practising certificates include the general practitioner, dietician, podiatrist and physiotherapist.
Six of six staff files randomly selected for audit include appointment documentation on file including signed contracts, job descriptions, reference checks and interviews. There is an annual appraisal process in place with all staff having a current performance appraisal. First aid and CPR certificates are held in staff file along with other training records.
Police checks are completed – sighted in all employee files reviewed.
All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract.
Health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Annual medication competencies are completed for all registered nursing staff and health care assistants who administer medicines to residents. Other competencies are

completed including hoist, oxygen use, hand washing, wound management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower.

The four health care assistants state that they value the training. Education and training hours exceed eight hours a year.

Mandatory training is identified on an Oceania wide training schedule. There are folders of attendance records and training with a spreadsheet maintained by support office with all training included. Staff training records are now maintained in a format that enables verification of completion of identified mandatory training by relevant staff. The improvement required at the certification audit has been met.

The business and care manager states that all 11 kitchen staff have a record of completing food service and hygiene training. Four files checked (two for the cooks and two kitchen assistants) include training around food services and hygiene given within the last year. The previous requirement identified at the certification audit is met.

The dementia unit is no longer operational therefore the previous improvement required around staff with dementia training is no longer an issue.

The District Health Board contract requirements are met.

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

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

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

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

<b>Timeframe (days):</b> (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)
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**Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

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

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

**Criterion 1.2.7.5 (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.

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

## **Standard 1.2.8: 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:**

The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.

The rosters for an occupancy of 75 residents are as follows:

There are two registered nurses on in the morning in the rest home and two in the hospital (one of the registered nurses in the rest home works a short shift only), one registered nurse in the rest home and two registered nurses in the hospital in the afternoons and one registered nurse overnight.

The business and care manager works full-time Monday – Friday and the clinical manager (registered nurse) works full-time when appointed. The clinical manager resigned in April 2014 and the service is continuing to actively recruit into the position. In the meantime, there is a bureau registered nurse who is appointed for a further four weeks with at least one and a half days support from the clinical leader at the sister site close by. The clinical and quality manager also supports the acting clinical manager in the interim.

There are six health care assistants in the morning in the rest home (three long shifts and three short shifts including one health care assistant with a medication competency) and five health care assistant in the hospital (three long and two short shifts).

In the afternoon, there are five health care assistants in the rest home (three short and two long shifts) and four in the hospital (two short and two long shifts).

Overnight there are two health care assistants each in the rest home and hospital.

Residents and families interviewed confirm staffing is adequate to meet the residents' needs.

There are currently 72 staff including the business and care manager, clinical manager (currently being recruited), 14 registered nurses, one activities coordinator and three activity assistants, two laundry assistants, four cleaners (seven days a week with the cleaning and laundry also provided for the sister site), three cooks and a kitchen manager (chef) and 33 health care assistants.

The District Health Board contract requirements are met.

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

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

### **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:

Each stage of service provision is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function. The acting clinical manager is from an agency supported by the clinical leader of the organisation's sister company. The previous clinical nurse manager resigned and the acting clinical manager is three days in the current role. The annual practising certificates sighted are all current. The registered nurses (RNs) admit new residents using standard assessment tools. The six out of six reviewed resident's files evidence that person centred care plans (PCCPs) are developed within three weeks from admission and are reviewed six monthly. The RNs develop short term care plans for acute infections as evidence in the six out of six reviewed resident's files.

The service uses an integration system where all staff, GP, allied health professionals, and other specialists write their notes as evidence in the six out of six reviewed resident's files. There are three communication books sighted (one in the kitchen, one in the hospital nurse's station and one in the rest home nurse's station). The RN's use the kitchen communication book when there are changes in the resident's dietary requirements while the communication books in the nurse's stations are used for hospital appointments, outings and family visitations.

The observed afternoon hand-over is comprehensive and resident focused. The provided interventions and effectiveness of the interventions are verbally handed-over by the RN to the next shift. The information's provided in the hand-over is congruent to the documentation in the progress notes. Example is when oxygen is given to a resident during the day of the audit. A hand-over form is utilised by the RN's.

Tracer Methodology (Rest home level of care)

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

Tracer Methodology (Hospital level of care)

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

The District Health Board contract requirements are met.

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

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

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

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

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

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Medication recording chart shows all regular non-packed medications like food supplements are given as charted by the GPs.  
The previous requirement has been addressed.

### **Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)**

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

**Attainment and Risk:** FA

**Evidence:**

All reviewed PCCPs have the appropriate interventions to guide all staff in achieving the resident's goals.

The previous requirement has been met.

### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

**Attainment and Risk:** FA

**Evidence:**

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

### **Standard 1.3.6: 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
Residents receive adequate and appropriate services in order to meet their assessed needs and desired goals. The six out of six PCCPs on the reviewed resident's files have sufficient and appropriate interventions to address the current needs and desired goals of the resident.

The relevant ARC requirements are met.

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

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

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service provides activities for the residents that are appropriate to the resident's needs, age, culture, and the setting of the service. Activities plan is integrated in the resident's PCCP. The activities coordinator reports that activities plan is developed within three weeks of admission. The recreational assessment forms the activities plan of the resident.

The District Health Board contract requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

The six out of six PCCPs in the reviewed resident's files are evaluated six monthly as sighted in the PCCP evaluation form. Evaluations are documented in the PCCP evaluation form, resident focused and indicates the degree of achievement or response to the interventions, and progress towards meeting the desired outcomes.

Short term and wound care plans/evaluations are not consistently developed for acute infections. This is area for improvement in 1.3.8.3.

The District Health Board contract requirements are not met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

When progress is different from expected, the service do not consistently respond by initiating changes in the service delivery plan. The six out of six reviewed resident's PCCPs reflect ongoing evaluation and update to address the resident's current needs.

**Finding:**

1. One out of four resident's wounds do not have wound assessments, wound care plans, evaluations or dressing change monitoring and there is no reference of this wound in the resident's progress notes.
2. Two out of four residents with urinary tract infections (UTI) do not have short term care plans developed. The medical notes evidence that an antibiotics is prescribed for the two residents.

**Corrective Action:**

Short term care plans and wound care plans/evaluations must be developed for acute infections.

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

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

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

There are policies and procedures in medicines management but are not consistently implemented by the service.

There are 23 unsigned/countersigned areas in the controlled drugs register from 8-December 2013 to 2-June 2014, not to mention previous unsigned areas prior to the specified timeframe. There are spaces between entries left by staff as sighted. The two health care assistants during the lunchtime and dinner medication rounds left the trolleys unlocked. These are areas for improvement in 1.3.12.1.

The GP conducts three monthly reviews in the 12 out of 12 reviewed medication charts. The “as required medications” in all 12 reviewed medication charts have clearly documented indications to guide the staff administering medications. A medicines management system is in place and is kept inside the medication trolleys in both rest home and hospital units. Medication stocks are stored in the medication rooms in both units. The unwanted and expired medications are kept in a plastic container inside the medication room and are regularly picked up by pharmacy staff. There are no expired or unwanted medications sighted during the audit. Controlled drugs are locked inside a locked vault in the hospital unit's medication room.

All staff administering medications have current medication competencies sighted (14 RNs, eight HCAs).

There is one resident who self-administers medication. A self-administration assessment is sighted with evidence of three monthly evaluations. The policies and procedures for self-administration are in place. The medicine management information is recorded to a level of detail, and communicated to the residents at a frequency and detail to comply with legislation and guidelines.

The District Health Board contract requirement D1.1g is not met.

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

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

**Attainment and Risk:** PA Moderate

**Evidence:**

A medicines management system is not consistently implemented to manage safe and appropriate administration in order to comply with the legislation, protocols, and guidelines. The GP prescribes medications for the residents that comply with the current medicine standards. Medication charts are reviewed three monthly by the GP. “As required” medications have indications documented to guide all staff who administers medications. All medications are packed by the pharmacy in a robotics system.

All staff who administers medications have current medication competencies as sighted. Controlled drugs are locked inside a locked cupboard while all robotics medications are kept inside the medication trolley in the hospital and rest home units. There are no expired medications sighted. The medication room fridge temperatures are checked daily/recorded as sighted. There are three sharps bins sighted during the audit. All unwanted and expired medications are kept in a separate container away from the rest of the medications are returned to the pharmacy within 24-48 hours.

**Finding:**

The medication trolley is left unlocked by two health care assistants while administering medications in two out of two observed medication rounds (one at lunch time, one at dinner time).

**Corrective Action:**

That staff will lock the medication trolleys when unattended.

2. All staff to comply with the policies and procedures in relation to administration and documentation of controlled drugs.
3. A system to be implemented to minimise errors in relation to administration and documentation of controlled drugs.
4. That staff will demonstrate better knowledge in relation to documentation of administered controlled drugs.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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 resident's individual food, fluids and nutritional needs are met when this service is a component of service delivery. Foods served by the service are appropriate and meets the recognised guidelines for the elderly. The food is well-presented and adequate portion is sighted during lunchtime. The four weeks winter and summer menus are last reviewed by the dietitian on March 2014.

Dietary profiles are both kept in the resident's files and in the kitchen file. Special diets are provided by the service to the residents. Additional food supplements are also provided for residents who are losing weight. Food temperatures are monitored and recorded by the cook. The fridge, freezer and chiller temperatures are recorded in the kitchen folder. All cooked and opened foods are labelled and dated properly. The kitchen is clean and the cleaning schedule is daily completed as evidence in the monitoring sheets.

The kitchen manager is a trained chef and is the role for 11 months. The kitchen manager rotates the stocks using the first in-first out system. There is no food that touches the floor.

The District Health Board contract requirements are met.

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

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

### **Attainment and Risk:** FA

#### **Evidence:**

#### **Finding:**

#### **Corrective Action:**

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

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

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

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

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

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

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

## 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:** PA Low

**Evidence:**

A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 26 November 2014). There have been no building modifications since the last audit.

There is a planned maintenance schedule implemented.

The lounge areas are designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounges on the day of the audit. The areas are suitable for residents with mobility aids.

The following equipment is available, pressure relieving mattresses, shower chairs, hoists and sensor alarm mats. There is a test and tag programme two yearly and this is up to date (last completed October 2013).

There are some chipped and scratched walls and doors, peeling wallpaper and metal wall heaters with rusty patches in the rest home and hospital. All the rusty radioators have been repainted. There are some chips however this is part of the normal wear and tear. There continues to be some peeling wallpaper noting that bedrooms in wing one, two have been refurbished along with some rooms in wings four and five. There is an ongoing maintenance and refurbishment programme in place that is continuing. All improvements identified at the previous audit have been addressed.

There are two bathrooms and a cupboards with wall and floor damage. All are non resident areas (confirmed by the business and care manager and the health care assistants interviewed). There is an improvement required to maintenance.

There are two safety issues identified in the certification audit for repair in the external area of the dementia unit. The dementia unit is now closed (empty apart from storing of furniture) and the environmental issues identified are therefore no longer identified as a requirements.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b>
Melrose Park operates from an older facility. There are some chipped and scratched walls and doors, peeling wallpaper and metal wall heaters with rusty patches in the rest home and hospital. All the rusty radiators have been repainted. All areas identified in the previous audit have been repaired. There are some chips however this is part of the normal wear and tear.
<b>Finding:</b>
There continues to be some peeling wallpaper since the last audit noting that bedrooms in wing one and two in the rest home have been refurbished along with some rooms in wings four and five. There is an ongoing maintenance and refurbishment programme in place that is continuing. There are two bathrooms and a cupboard with wall and floor damage. All are non resident areas (confirmed by the business and care manager and the health care assistants interviewed). All issues related to maintenance are identified on the planned maintenance list.
<b>Corrective Action:</b>
Address issues related to maintenance in bathrooms and cupboards as planned.
<b>Timeframe (days):</b> 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

## **Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)**

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

### **Attainment and Risk:** FA

#### **Evidence:**

An improvement related to hot water temperatures in resident areas not being consistently maintained at or below 45 deg Celsius was identified in the previous certification audit.

The issue around hot water with temperatures over 45 Deg C has been resolved with the addition of tempering valves on all cylinders and taps where issues have been identified. There is a system in place described by the business and care manager and maintenance staff member to put signs up when issues are identified and evidence of corrective actions if any temperatures are identified as being over 45 deg Celsius. The management and quality and risk meeting minutes in 2013 consistently discuss progress to resolution of the water temperatures.

The previous requirement has been addressed.

### **Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)**

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

### **Attainment and Risk:** FA

#### **Evidence:**

#### **Finding:**

#### **Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An improvement required was identified in the dementia unit lounge where a designated fire exit sign was not identified. The dementia unit is no longer operational. The previous requirement has therefore been addressed.

There is evidence in training records that fire and evacuation training has been provided twice in the last 12 months. All staff have attended the training in the last year. The previous requirement has been addressed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

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

# 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  There is currently no residents using an enabler. Two staff interviewed demonstrates good knowledge about restraints and enablers. The restraint minimisation policies and procedures are implemented and the use of restraint is actively minimised by the service. The restraint training is last conducted on March 2014 where restraint and enabler are differentiated as sighted in the in-service education hand-out.  The District Health Board contract requirements are met.

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

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
The surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have specified in the infection control programme. The infection control surveillance is appropriate to the size of the service. Infection rates are monthly monitored and collated by the infection control coordinator including urinary tract infections, skin, wound, chest, gastro-intestinal tract, ears/ear infections and systemic. These infections are entered in the intranet system for benchmarking with other services within the organisation. Infection rates are discussed during staff meetings to prevent and manage infections in the facility as sighted in the previous staff meetings.  The results of the monthly surveillance are sighted in the infection control folder

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

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

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

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

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