

The Ultimate Care Group Limited - Oakland Lifecare

Current Status: 20 August 2014

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

General overview

Oakland Lifecare provides rest home and hospital level care for up to 84 residents in six wings on two floors. There are 74 residents in Oakland Lifecare on the first day of this audit with 38 residents requiring hospital level care, 25 residents requiring rest home level care and 11 residents under the age of 65 years with physical and / or intellectual disabilities. The facility is operated by Ultimate Care Group Limited.

This audit included a review of the 10 aspects of service provision identified as requiring improvement at the previous surveillance audit in February 2014, two of which have not been fully addressed. The areas that have not been fully addressed relate to the management of corrective action plans and the currency of performance appraisals for staff. There are no new areas identified at this audit that require improvement.

Audit Summary as at 20 August 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 20 August 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 20 August 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 20 August 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 20 August 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 20 August 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 20 August 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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HealthCERT Aged Residential Care Audit Report (version 4.2)

Introduction

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

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

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

Audit Report

Legal entity name:	The Ultimate Care Group Limited		
Certificate name:	The Ultimate Care Group Limited - Oakland Lifecare		
Designated Auditing Agency:	The DAA Group Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Oakland Lifecare		
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical		
Dates of audit:	Start date: 20 August 2014	End date: 21 August 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:			74

Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	6
Other Auditors	XXXXX	Total hours on site	12	Total hours off site	6
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	24	Total audit hours off site	14	Total audit hours	38
Number of residents interviewed	7	Number of staff interviewed	15	Number of managers interviewed	3
Number of residents' records reviewed	8	Number of staff records reviewed	10	Total number of managers (headcount)	3
Number of medication records reviewed	14	Total number of staff (headcount)	100	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	3			Number of GPs interviewed	1

Declaration

I, XXXXX, Managing Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The 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 Monday, 1 September 2014

Executive Summary of Audit

General Overview

Oakland Lifecare provides rest home and hospital level care for up to 84 residents in six wings on two floors. There are 74 residents in Oakland Lifecare on the first day of this audit with 38 residents requiring hospital level care, 25 residents requiring rest home level care and 11 residents under the age of 65 years with physical and / or intellectual disabilities. The facility is operated by Ultimate Care Group Limited.

This audit included a review of the 10 aspects of service provision identified as requiring improvement at the previous surveillance audit in February 2014, two of which have not been fully addressed. The areas that have not been fully addressed relate to the management of corrective action plans and the currency of performance appraisals for staff. There are no new areas identified at this audit that require improvement.

Outcome 1.1: Consumer Rights

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

The area requiring improvement from the last audit relating to not all complaints being recorded in the complaints register has been addressed. The facility manager is responsible for complaints and a complaints register is maintained, with all complaints recorded. The residents and their family members can use the complaints issues forms or raise issues at the residents' monthly meetings.

The service provides an environment conducive to effective communication.

The area requiring improvement from the last audit relating to the management of advance directives has been fully addressed. Advance directives were sighted and signed by the resident or the general practitioner if, in the opinion of the general practitioner, the resident is not competent to sign.

Outcome 1.2: Organisational Management

The Ultimate Care Group Limited is the governing body and is responsible for the service provided at Oakland Lifecare. A 'Quality and Risk Management Plan for Oakland Lifecare' was reviewed and included a vision statement, values, quality objectives, quality and risk management plan, quality indicators and quality projects. Systems are in place for monitoring the service provided at Oakland Lifecare including regular monthly reporting by the facility manager to the Ultimate Care Group Head Office. The facility is managed by a suitably qualified and experienced facility manager who is a registered nurse with aged care experience. The facility manager started in this role in July 2014 and is supported by an experienced clinical services manager / registered nurse who is responsible for oversight of clinical care.

The Ultimate Care Group quality and risk management systems are in place at Oakland Lifecare. There is evidence that quality improvement data is collected and collated, and corrective actions plans developed. The area requiring improvement at the last audit relating to quality improvement data not being analysed to identify trends and improve service delivery has been addressed. The area identified as requiring improvement during the last audit relating to the management of corrective action plans has not been fully addressed and improvements are still required. There is an internal audit programme, risks are

identified, and there is a hazard register. Adverse events are documented on accident/incident forms and an electronic database that is able to be reviewed by personnel from the Ultimate Care Group Head Office.

There are policies and procedures on human resources management and all health professionals have the required current practising certificates. Inservice education is provided for staff via four study days that staff are rostered to attend and this is supplemented by additional education sessions. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards via Careerforce. Areas requiring improvement relating to staff education and orientation have been addressed. However, the area identified at the last audit relating to not all staff having current performance appraisals remains an area requiring improvement. Review of staff records provides evidence of human resources processes being followed, including reference checking and criminal record vetting. Interview questionnaires are completed and individual education records are maintained.

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

Outcome 1.3: Continuum of Service Delivery

There is evidence that residents' needs are assessed on admission and three monthly or as needs change. Care required is identified, co-ordinated, planned and reviewed in participation with the resident. A previous required improvement has been addressed with short term problems being included in care plan documentation.

An activities programme, that includes a diversity of activities and involvement with the wider community, is enjoyed by residents. There are specifically designed activities for the younger residents.

Well defined medicine policies and procedures guide practice, and practices observed are consistent with these documents. A previous required improvement around medicine fridge temperatures and medication errors has been addressed

Menus are reviewed by a dietitian with any special dietary requirements and need for feeding assistance or modified equipment recorded and being met. Residents have a role in menu choice. Management has identified corrective actions required around the food service and these are being implemented. A previous required improvement around food management in the freezer has been addressed.

Outcome 1.4: Safe and Appropriate Environment

The facility manager advised there have not been any alterations to the building since the last surveillance audit. A Building Warrant of Fitness was displayed at the main entrance and expires on 6 January 2015.

Outcome 2: Restraint Minimisation and Safe Practice

Policies and procedures implemented meet the requirements of the standards. There are eight residents using restraint and one resident using an enabler at the time of audit. The service maintains a process to determine approval for all types of restraint, including enablers.

Outcome 3: Infection Prevention and Control

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported through all levels of the organisation, including governance.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	16	0	2	0	0	0
Criteria	0	39	0	0	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	32
Criteria	0	0	0	0	0	0	0	60

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Moderate	Corrective action plans are not consistently documented in meeting minutes to address all areas identified as requiring improvement, do not consistently provide evidence that the corrective action plan has been implemented, monitored, and signed off as having been	Provide documented evidence that minutes of meetings have corrective action plans documented, implemented, monitored, and signed off as having been completed within identified timeframes.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				completed, and timeframes for completion of the corrective actions are not being consistently documented. It is noted that a new form has been developed that is to be implemented for meeting minutes that includes sections for corrective actions, timeframes, staff who are responsible for completing the corrective action, and sign off when closed out.		
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	Six of the 10 staff files reviewed do not have evidence of current performance appraisals completed.	Provide documented evidence that all staff have current performance appraisals.	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:

The services provided by Oakland Lifecare are conducive to an environment of effective communication.

Communication with relatives is documented in the communication sheet which is kept in the resident's file, and sighted incident and accident forms evidence resident and/or family are informed of incidents, when requested. The service has an open disclosure policy which provides guidance to staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the annual education programme (records sighted). Staff confirm they understand that relatives and residents must be informed of any changes in care provision.

There are no residents that require interpreting services, however management staff are aware of how to access interpreters, through the NZTC (the international translation centre) if this service should be required.

Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed).

On admission, the resident and their family/whanau are given information and a discussion is held to clarify what they wish to be informed about and at what time of day they wish to be notified (documentation sighted).

Residents and family interviews confirm communication with staff is open and effective, that they are always consulted and informed of any untoward event or change in care provision, and are included in care reviews (sighted in files reviewed).

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

A previous corrective action around advance directives has been addressed. An advance directive enables a resident to choose if they would like resuscitation in the event of cardiac, respiratory or cerebral collapse. The advance directive is filled out in consultation with the resident's doctor and residents' wishes guide care planning, with consent on non consent to be revoked at any time. Advance directives are sighted in files reviewed.

The ARRC requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Areas requiring improvement identified at the last audit relating to the management of complaints have been addressed. The complaints register has been restarted from the 11 March 2014 and is maintained with all complaints (24 internal) entered. The complaints 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 recorded complaint is held in the complaint's folder.

Two internal complaints recorded in 2014 are selected for review. There is documented evidence of time-frames being met for responding to these complaints with documentation indicating that the complainant is happy with the outcome for one complaint reviewed. The other complaint reviewed is currently being investigated.

Reporting of complaints occurs via monthly meetings and via the facility managers' reports to the UCG Head Office. The facility manager and the audit and compliance manager from UGC Head Office advise there have been no complaint investigations by the Health and Disability Commissioner, the District Health Board, Ministry of Health, Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.

Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents are advised on entry to the facility of the complaint processes and the Code. The admission information pack includes information on complaints and the Code and copies of these are given to all residents and their families as part of the admission process. Residents and family interviewed demonstrate an understanding and awareness of these processes. Residents meetings are held monthly and review of these minutes provides evidence of residents' ability to raise any issues they have. This was confirmed during interviews with residents.

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

The 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: 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 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Oakland Lifecare. A 'Quality and Risk Management Plan for Oakland Lifecare – January 2014 to January 2015' is reviewed and includes a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Also reviewed are documented values, mission statement and philosophy, which are displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.

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

There is an 'Ultimate Care Group Clinical Advisory Group' (CAG) in place that comprises of three clinical services managers (CSMs), one facility manager, two regional managers, audit and compliance manager and clinical quality and Lead InterRAI practitioner who are responsible for reviewing clinical issues and policies and procedures following feedback from each of the UCG sites.

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

Oakland Lifecare has a facility manager (FM) who commenced employment on the 21 July 2014. Prior to this appointment there were two acting facility managers managing Oaklands Lifecare from within UGC. The FM is a registered nurse with a current practising certificate with an extensive background in aged care, both overseas and in New Zealand including working in aged care facilities. The FM's personal file is reviewed and includes their CV, practising certificate and evidence of ongoing education. The FM has completed a diploma in ethics and law in the aged care community, a post graduate certificate in clinical studies, and is an enrolled nurse (EN) assessor for the Nursing Council of New Zealand. The FM is supported by a CSM / registered nurse (RN) who is responsible for oversight of clinical care provided to residents. The CSM has been in this position since May 2013. Prior to being appointed as the CSM, the CSM was employed as an enrolled nurse (EN) for four years and then as a RN from 2006.

Twenty four hour RN cover is provided. Support for the FM and CSM is provided by a regional operations manager and the audit and compliance manager for UGC.

Oakland Lifecare is certified to provide medical and geriatric hospital level care, rest home level care and physical and / or intellectual disabilities residential care. There are 84 beds provided. There are four rest home beds in the Pohutukawa wing that are used for either rest home or hospital use. On day one of this audit there are 38 hospital residents, 25 rest home residents, 11 residents aged less than 65 years with a physical and / or intellectual disability.

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

The district health board 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.

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

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

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

Attainment and Risk: PA Low

Evidence:

Criterion 1.2.3.8 was partially attained at the last audit and remains partially attained because although corrective action plans are being developed, they are not always implemented, monitored and documented in meeting minutes. (See criterion 1.2.3.8) A further area requiring improvement identified at the last audit relating to clinical indicators and adverse events not being analysed to identify any trends is addressed. There is evidence available to indicate that clinical indicators and adverse events are being analysed to identify any trends. Documentation reviewed includes comprehensive analysis that identifies trends with corrective actions and prevention as a result of a high number of falls, concerns about the food service, and the number of residents with the 'flu'.

The Ultimate Care Group (UCG) 'Quality and Risk Management Plan – 2013-2014' is used to guide the quality programme and includes quality goals and objectives. The Ultimate Care Group (UCG) quality and risk management systems are in place at Oakland Lifecare.

There is an internal audit programme in place and completed internal audits for 2013 and 2014 are reviewed. Review of quality improvement data provides evidence the data is being reported to Ultimate Care Group Head Office via the UCG intranet as well as to staff via various meetings. Separate quality improvement and staff meetings are held monthly and there is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Registered nurse (RN) meetings are also held monthly, as are resident meetings, and meeting minutes are reviewed. All staff interviewed, including five of five RNs, five of five health care assistants, the activities coordinator, the CSM, and the cook, report they are kept informed of quality improvements. Month by month graphs of various clinical indicators for 2014 are reviewed, and graphs are displayed on the noticeboard in the staff room.

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

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

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

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

Not all of the district health board 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

This criterion was partially attained at the last audit and although there has been improvement with regards to corrective action plans developed following internal audits and incidents and accidents, minutes of meetings reviewed where areas requiring improvement are identified do not consistently record implementation, who is responsible, monitoring and completion to address all of the areas that require improvement. This remains an area requiring improvement.

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

Finding:

Corrective action plans are not consistently documented in meeting minutes to address all areas identified as requiring improvement, do not consistently provide evidence that the corrective action plan has been implemented, monitored, and signed off as having been completed, and timeframes for completion of the corrective actions are not being consistently documented. It is noted that a new form has been developed that is to be implemented for meeting minutes that includes sections for corrective actions, timeframes, staff who are responsible for completing the corrective action, and sign off when closed out.

Corrective Action:

Provide documented evidence that minutes of meetings have corrective action plans documented, implemented, monitored, and signed off as having been completed within identified timeframes.

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

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The adverse event reporting system provides evidence of a planned and co-ordinated process. Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG GOSH / Inscribe electronic database, and filed in residents' files. An 'Incident Management Form' is used to document all incidents that are escalated to UCG head office. Data reviewed for 2014 includes summaries of various clinical indicators including falls, medication errors, unintentional weight loss, skin tears, and 'behaviour'. Documentation reviewed and interviews of staff indicates appropriate management of adverse events.

There is an open disclosure policy. Resident files reviewed (four hospital, two rest home, and two aged under 65 years) provide evidence of communication with families following adverse events involving the resident, or any change in the resident's condition.

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

The district health board 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Criterion 1.2.7.5 was partially attained at the last audit. Requirements identified at the last audit relating to staff education have been addressed. Ten of 10 staff files are reviewed and provide evidence of education sessions staff have attended. The education programme for 2014 is reviewed and spread sheets reviewed provides evidence of education on medicine management for staff that are responsible for the administration of medicines, and all staff have attended education on challenging behaviour and restraint minimisation. However, not all staff have current performance appraisals and this remains an area for improvement. (See criterion 1.2.7.5).

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

The FM advises a registered nurse is employed for four hours a week as the quality and education co-ordinator. The quality and education co-ordinator is also the onsite Careerforce assessor and the FM states staff are encouraged to complete Careerforce education.

Four staff study days are provided each year and staff are rostered to attend one of these study days each year. The FM advises during interview that inservice education is also provided monthly to supplement these study days.

Criterion 1.2.7.4 was partially attained at the least audit relating to not all staff had completed an orientation/induction programme prior to their commencement of care to residents is addressed. Ten of 10 staff files reviewed have completed orientations. Care staff interviewed confirm they have completed an orientation, including competency assessments (as appropriate). Care staff also confirm their attendance at on-going in-service education; however, not all staff interviewed could recall when they last completed a performance appraisal.

Not all of the district health board 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.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

This criterion was partially attained during the last audit and remains partially attained. Documentation reviewed shows 71 of the 100 staff employed have a current performance appraisal.

The education programme for 2014 is reviewed and indicates staff are rostered to attend one of the four full day study days that are provided throughout the year. Staff files and spreadsheets provide evidence that staff attend one of these days per year. The senior administrator manages the education and competency spreadsheets and this is reviewed during this audit.

The FM and CSM are responsible for management of the inservice education programme and there is evidence available indicating inservice education is provided via the staff study days that are provided three monthly. The FM during interview advises that inservice education is also provided monthly, and is included in the education programme. The content of the study days is reviewed and includes sessions on challenging behaviour, infection control and hazardous waste substances, health and safety, fire safety and civil defence, quality, consumer rights, activities and restraint minimisation.

Staff are supported to complete the New Zealand Qualifications Authority Unit Standards via Careerforce

Finding:

Six of the 10 staff files reviewed do not have evidence of current performance appraisals completed.

Corrective Action:

Provide documented evidence that all staff have current performance appraisals.

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

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

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

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

Attainment and Risk: FA

Evidence:

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

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

The district health board 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 the service provision at Oakland Lifecare is undertaken by a suitably qualified provider and is developed with the resident and their family/whanau.

Within 24 hours of admission the initial assessment process is undertaken by the registered nurse (RN) and includes gathering data from the resident, their family / nominated representative, the needs assessment and co-ordination service and / or previous providers of personal care services. Data gathered informs the initial documented plan of care the staff require to meet the resident's immediate needs. A medical assessment is conducted by the resident's general practitioner (GP) within 24 hours of admission and the medical treatment programme required by the resident is documented. This serves as the basis for care planning to cover a period of up to three weeks.

Within three weeks of admission the RN completes a long term care plan, based on the collection of comprehensive assessment data. The long term care plan directs the care required to meet the resident's need and desired outcome. Progress notes, recording the daily progress of the resident, are documented by the care staff providing the care and the RN (where RN input is required) each shift. The ongoing assessments, interventions and evaluation is completed and documented by the RN in consultation with the resident, family and allied professionals as residents needs change. The care plan is evaluated every three months, or as needs change, to ensure the appropriate care is provided and the residents' desired outcomes are being met.

Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. The resident's medication is reviewed three monthly or as needs change and this is conducted by the GP.

Family contact is documented in the family contact record.

Evidence of this is sighted in files reviewed (four of four hospital, two of two rest home and two of two young person with disability) and verified by residents (three of three hospital, two of two rest home and two of two younger persons with a disability) and family (two of two hospital and one of one rest home) interviews. Residents and family/whanau are happy with the quality of care that is provided as evidenced by interviews.

Registered nurses practising certificates, medication competencies, training records and first aid certificates are sighted. The registered nurse acts as the resident's case manager and is responsible for planning, reviewing and overseeing all aspects of the residents care. Caregivers with experience, education and training in aged care (as evidenced by training records) provide most of the direct provision of care. The in-service education programme (sighted) contains the required education for the staff to meet contractual requirements. The cooks and kitchen assistants have qualifications in food safety training. The contracted physiotherapist and podiatrist provide services to the residents. The annual practising certificates (APCs) are sighted for all other staff and contracted staff that require an APC.

Each RN oversees the residents whose care they are responsible for planning. Residents are attended to by their GP of choice or the facility contracted GP service. A verbal handover by the RN occurs at the beginning of each shift to ensure all staff are familiar with the residents' needs (observed). Health professionals are allocated the residents they are to deliver the daily care to, under the guidance of the RN, and write in the resident's progress notes at the end of each shift. Resident notes are integrated and demonstrate input from a variety of health professionals, and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in resident's files, where specialist input is required.

The ARRC contract requirements are met.

Tracer methodology 1

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

Tracer methodology 2

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

Tracer methodology 3

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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:

A previous corrective action around assessment and interventions related to short term problems has been addressed. Residents at Oakland Lifecare have their needs identified through a variety of information sources that includes the needs assessment coordination (NASC) assessment, other service providers involved with the resident, the resident, family/whanau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the care planning and care delivery process. The assessments are reviewed three monthly as needs, outcomes and goals of the resident change. Evidence of this is sighted in files reviewed. Resident and family interviews, verify they are included and informed of all assessment updates and changes.

Staff interviewed (10 of 10 clinical) confirm they used the information in the resident's care plan, as well as information given at handover, to ensure appropriate services and interventions are provided to meet the residents' needs.

The ARRC requirements are met.

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

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

Attainment and Risk: 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 care and services at Oakland Lifecare are delivered in a safe and respectful manner as evidenced in files reviewed and in resident and family interviews.

The provision of care is consistent with the residents' assessed physical, social, spiritual and emotional needs and desired outcomes. Interventions are detailed, accurate and meet current best practice standards as verified by file documentation and clinical staff interviews.

The GP interviewed expressed confidence in the services provided by Oakland Lifecare and was complimentary of the improvement in services and the facility allowing residents to have their pets. She stated residents at times complained to her about the food (refer 1.2.3.8).

Interviews with residents and family/whanau members expressed satisfaction with the care provided. Two of two new residents verify they were made welcome and orientated to the facility when first admitted.

There are sufficient supplies of equipment that complies with best practice guidelines and meets the resident's needs (sighted).

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.

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 1.3.7: 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:

Two diversional therapists and an activities person are employed at Oakland Lifecare with activities offered six days per week.

On admission, residents are assessed to ascertain their needs and appropriate activity requirements. The activities assessments and plans include the resident's preferences, social history, and past and present interests. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in the activity assessment data.

Activities reflect ordinary patterns of life and include normal community activities (eg, van outings, visiting entertainers, visiting school groups, dog squad, Kapa Haka, craft groups, church services and home visits). Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group and individual activities are developed according to the needs and preferences of the residents who choose to participate.

Individual activity assessments are updated or reviewed at least three monthly with a monthly summary of the resident's response to the activities, level of interest and participation recorded. The goals are developed with the resident and their family, where appropriate, as evidenced by file reviews, resident and family interviews.

A residents' meeting is held monthly and meeting minutes evidence that the activities programme is discussed. The yearly resident/relative satisfaction survey also captures feedback on the activities programme. The local Health and Disability Commissioner representative meets with the residents at some residents' meetings and the residents know she is accessible.

Residents and family are satisfied with the activities offered.

The two diversional therapists interviewed report feedback is sought from residents during and after activities.

The ARRC 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: FA

Evidence:

Evaluation of resident care is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may contact the GP if requested. Family/whanau are kept informed of changes.

Formal care plan evaluations are conducted at least three monthly or as needs change. Evaluation measures the degree of achievement or response of each resident related to their goals. Where progress is different from expected, the service responds by initiating changes to the service delivery plan. When a resident is not responding to the services or interventions, changes are initiated to the care plan. A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition.

The RN undertakes and documents all care plan evaluations. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.

Evidence of evaluation is sighted in files reviewed. Resident and family interviews verify they are included and informed of all care plan updates and changes.

The ARRC requirements are met.

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The Medication Management Policy at Oakland Lifecare is comprehensive and identifies all aspects of medicine management, including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation, in order to comply with legislation, protocols and guidelines.

Medicines for residents are received from the pharmacy in the Medico Pak delivery system. A safe system for medicine management is observed on the day of audit. All staff who administer medicines have current medication competencies (sighted). The staff observed demonstrate good knowledge and have a clear understanding of their roles and responsibilities related to each stage of medicine management.

Controlled drugs are stored in separate locked cupboards, in locked rooms. Controlled drugs, when dispensed, are checked by two RNs. The controlled drug register evidences weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded.

A previous corrective action around fridge temperatures has been addressed. The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range

The medicine prescription is signed individually by the GP. The GP's signature and date are recorded on the commencement and discontinuation of medicines. Residents' photos, allergies and sensitivities are recorded on the medicine chart. Sample signatures are documented. All medicine charts reviewed have fully completed medicine prescriptions and have signing sheets including approved abbreviations when a medicine has not been given. The three monthly GP review is recorded on the medicine chart.

There are some residents who self administer inhalers or sprays at the time of audit. The sighted assessments for self administration monitoring and review is in the resident's medication files and meets the facility's policy.

A previous corrective action around medication errors has been addressed. Medication errors are reported to the senior RN/team leader, recorded on an incident form and investigated and analysed by the clinical manager. The resident and/or the designated representative are advised. Incident of drug errors is evident in incident forms sighted. The manager and clinical manager are aware of recent drug errors with analysis and corrective actions in place to address identified risks (refer 1.2.3.8).

The team leaders monitor to ensure all staff who administer medications have current competencies and these are checked and signed off by the clinical manager. RNs are assessed for medication competency yearly and approved senior healthcare workers are certified as competent in medication administration in the rest home (documentation sighted), under the direction and delegation of a RN.

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

The ARRC requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.12.6 (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 food, fluid and nutritional requirements of the residents at Oakland Lifecare are provided in line with recognised nutritional guidelines for older people as verified by the dieticians documented assessment of the planned menu, that changes seasonally (sighted).

Training records verify the cook and kitchen staff are trained in food and hygiene safety.

Ecolab monitor chemical use, cleaning and food safety in the kitchen and inform the facility with monthly reports and recordings. A cleaning schedule is sighted as is verification of compliance.

There is evidence to support sufficient food is ordered and prepared to meet the resident's recommended nutritional requirements.

A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs are sighted. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed, sighted and roster reviewed. The dining rooms are clean, warm, light and airy to enhance the eating experience.

Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, however not by all. Sighted satisfaction surveys and residents' meeting minutes note an ongoing dissatisfaction with meals, though interviews verify it has improved recently. Management is aware and corrective actions are in place to address this concern (refer 1.2.3.8).

Food is ordered by the cook on a weekly basis. Fruit and vegetables are ordered twice weekly depending on need and availability and meats and fish are ordered as required. When food is delivered it is checked for 'use by date' and damage then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, chiller and cooked meat temperatures are monitored daily. Records sighted verify records within accepted parameters. A previous corrective action around food storage has been addressed. Raw meat is stored at the bottom of the fridge and is completely thawed before cooking. Any leftovers are covered and labelled with the date / time / contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days.

The ARRC 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.

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

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

Attainment and Risk: FA

Evidence:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

The audit and compliance manager and FM advise there have not been any alterations to the building since the last audit. A Building Warrant of Fitness is displayed at the main entrance that expires on 6 January 2015. The facility manager advises that six of the 10 beds are vacant in one of the wings in readiness for refurbishment.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The Policy sighted states the use of enablers as “voluntary use of equipment by a resident that limits normal freedom of movement with the intention of promoting independence, comfort of safety”. There are eight residents currently using restraint and one resident using an enabler at Oakland Lifecare. The file of the resident using an enabler is reviewed. The resident’s file has a documented request by the resident requesting an enabler. An assessment, approval for the use of an enabler by the approval group is sighted. There is evidence of ongoing three monthly reviews and evaluation, and evidence of monitoring the resident when the enabler is being used.

The restraint coordinator is the CSM who states the use of restraint is actively minimised. The restraint register reviewed shows the use of restraint has decreased by three, from 11 to eight residents using restraint since the last audit. The restraint coordinator states this has been achieved by the use of low beds, landing pads, bell mats and education. A comprehensive analysis of all residents that are falling frequently has also helped in the management of restraint use.

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:

In line with Oakland Lifecare Infection Control (IC) policy, monthly surveillance is occurring, as observed in surveillance records. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form and graphed. These are collated each month and analysed to identify any significant trends or possible causative factors. Currently there is a continuous quality improvement' (CQI) meeting every month and a staff meeting every month where the incidents of infection are presented, as evidenced by meeting minutes. Any actions required are implemented. Outcomes are presented to staff at daily handover and staff meetings and any necessary corrective actions discussed. Management meetings also review infection information. As evidenced by surveillance records, clinical staff interviews and meeting minutes.

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.)*