Metlifecare Coastal Villas Limited

Current Status: 7 October 2014

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

General overview

Metlifecare Coastal Villas is a 35 bed hospital and rest home that adjoins a village complex. This includes five apartments used for rest home care only. Of the 30 hospital beds in the main facility, seven can be used for either hospital or rest home residents. The facility is owned and operated by Metlifecare Limited. On the day of this audit there are 29 hospital and six rest home level care beds occupied.

The service has a recently appointed nurse manager (March 2014), who is an experienced manager. There is also a senior registered nurse who has been employed since December 2013 who is experienced in aged care. Both hold current annual practising certificates.

The eight areas shown as requiring improvement in the previous audit are now fully attained.

No new areas for improvement were identified.

Audit Summary as at 7 October 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 7 October 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.

Organisational Management as at 7 October 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.

Continuum of Service Delivery as at 7 October 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.

Safe and Appropriate Environment as at 7 October 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.

Restraint Minimisation and Safe Practice as at 7 October 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.

Infection Prevention and Control as at 7 October 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.

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:	Metlifecare Coastal Villas Limited
Certificate name:	Metlifecare Coastal Villas Limited

Designated Auditing Agency:	The DAA Group Limited

Types of audit:	Surveillance Audit
Premises audited:	Metlifecare Coastal Villas
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	**Start date:** 7 October 2014 **End date:** 7 October 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	35

Audit Team

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

Sample Totals

Total audit hours on site	16	Total audit hours off site	10	Total audit hours	26

Number of residents interviewed	4	Number of staff interviewed	9	Number of managers interviewed	3
Number of residents' records reviewed	6	Number of staff records reviewed	7	Total number of managers (headcount)	3
Number of medication records reviewed	12	Total number of staff (headcount)	68	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXXXXX , 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 Friday, 24 October 2014

Executive Summary of Audit

General Overview

Metlifecare Coastal Villas is a 35 bed hospital and rest home that adjoins a village complex. This includes five apartments used for rest home care only. Of the 30 hospital beds in the main facility, seven can be used for either hospital or rest home residents. The facility is owned and operated by Metlifecare Limited. On the day of this audit there are 29 hospital and six rest home level care beds occupied.

The service has a recently appointed nurse manager (March 2014), who is an experienced manager. There is also a senior registered nurse who has been employed since December 2013 who is experienced in aged care. Both hold current annual practising certificates. On the day of audit the organisation was represented by the Metlifecare clinical quality and risk manager.

The eight areas shown as requiring improvement in the previous audit are now fully attained. No new areas for improvement were identified.

The requirements of the provider's agreement with the district health boards are met.

Outcome 1.1: Consumer Rights

Metlifecare Coastal Villas provides an environment conducive to effective communication.

All complaints are managed to meet good practice and policy guidelines. There are no outstanding complaints at the time of audit.

Outcome 1.2: Organisational Management

Organisational structures and processes are monitored at organisational level via a computerised risk management system. Service performance is aligned with the organisation's philosophy and goals as identified in the Metlifecare Coastal Villas site specific business plan. Quarterly monitoring of set goals is reported on by management at organisational level.

The nurse manager is suitably qualified, with delegated authority, accountability and responsibility for the provision of service.

Key components of service delivery, including infection control, health and safety, restraint, complaints management and adverse event reporting, are linked to the organisational quality system. Regular audits and reporting systems are in place to identify any service deficits. All identified deficits are addressed through a corrective action process and used to improve services as appropriate.

There is an up to date risk register which outlines controls that are in place to minimise actual and potential risks.

All incidents, accidents and untoward events are reported, recorded, evaluated and the results are compared with other similar facilities. A review of residents' files and resident and family/whanau interviews confirm adverse events are reported and discussed in an open and honest manner.

Staffing levels are monitored at organisational level to ensure safe staffing levels and skill mix requirements are met. Human resources management processes in place meet policy requirements. Staff education is planned, reviewed, monitored and evaluated to ensure it is relevant to service provision.

Outcome 1.3: Continuum of Service Delivery

There is evidence that residents' needs are assessed on admission by the multidisciplinary team. All residents' files sighted provide evidence that needs, goals and outcomes are identified and that these are reviewed on a regular basis with the resident and where appropriate their family. The six previous areas requiring improvement have been attended to. Evidence is sighted of a co-ordinated approach to care planning, monitoring of fridge temperatures and the checking of medications against the prescription prior to dispensing.

An activities programme, that includes a wide range of activities and involvement with the wider community, is enjoyed by residents.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents.

The menu has been reviewed as meeting nutritional guidelines by a registered dietician, with any special dietary requirements and need for feeding assistance or modified equipment recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided.

Outcome 1.4: Safe and Appropriate Environment

The service has a current building warrant of fitness. The area identified for improvement from the previous audit related to electrical safety checking is now fully attained.

Outcome 2: Restraint Minimisation and Safe Practice

The service has seven enablers and seven restraints in use. They are all bedside rails used for safety. Enabler use is voluntary. One area identified for improvement in the previous audit is now fully attained and all restraint is appropriately evaluated to identify safe practice.

Outcome 3: Infection Prevention and Control

Surveillance of infections at Metlifecare Coastal Villas is occurring according to the descriptions of the process in the infection control 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	18	0	0	0	0	0
Criteria	0	41	0	0	0	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)

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:

Metlifecare Coastal Villas provides an environment conducive to effective communication. Communication with relatives is sighted in documentation on the communication sheet in the resident's file. Accident and incident 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 by the registered nurse (RN).

There are no residents that require interpreting services; however management staff are aware of how to access interpreters, if this service should be required.

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

Residents and family interviews (five residents and three residents' family) 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 as sighted in files (two rest home and four hospital) 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 1.1.13: 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:

Complaints are actively managed in a timely manner and in accordance with Metlifecare's complaint management policy, and/or any other statutory requirements relevant to the specific situation. All complaints sighted are of a minor nature and have been closed off. There are no open complaints at the time of audit. This is confirmed on the organisation's electronic complaints recording system (Amrisk) and in the complaints register sighted.

Complaints management information is included in resident admission packs and is discussed as part of the admission process. Complaints forms are on display at the front entrance and available from the reception area. Interviews with nine of nine staff (one RN, four caregivers, one activities coordinator, one cook, one laundry assistant and one cleaner), four of four family/whanau members and four of four residents (three hospital and one rest home level) confirm their understanding of the complaints process.

Staff meeting minutes confirm that complaints are discussed at all staff levels. The manager confirms there have been no Coroner's inquests or police investigations since the previous audit.

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:

Policy identifies that the Board of Metlifecare is responsible for the governance of the company on behalf of shareholders. The manager of Metlifecare Coastal Villa reports to the Board on key management parameters including such matters as financial performance, risks and risk management, statutory and legislative compliance quarterly. The purpose, scope, direction and goals of the organisation are clearly defined in the business plan which is reviewed annually.

The nurse manager is a RN who has a current practising certificate and has many years' experience in management positions. She has the authority, accountability and responsibility for the provision of service shown in her job description. Her education and training ensures her knowledge and skills are maintained related to her role. She has a direct reporting line to the village manager who has been in her role for many years and is very experienced in aged care and also holds a current nursing annual practising certificate. The senior register nurse (SRN) who supports the nurse manager, has a Master's of Nursing in aged care and post graduate qualifications in gerontology. The SRN oversees all clinical aspects of the service.

Interviews with four of four family/whanau members and four of four residents confirm they are satisfied with the services provided and that their needs are met. They report they have access to members of the management team at any time.

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: FA

Evidence:

Metlifecare have a detailed quality and risk management system in place which is understood and implemented by the management team at Coastal Villas. A risk management planning and reporting document is sighted. This highlights when and at what level of the organisation any particular risk is reported at depending on the identified risk severity. For example, a critical risk is reported to the Board, the CEO, general manager and manager on a weekly basis whilst a low risk is reported on monthly at management level. The risk management schedule (sighted) is reviewed and reported on monthly by the nurse manger. Where required appropriate corrective action planning is identified. Information is gathered from all key components of care including audits, complaints management, resident satisfaction surveys, regular data collection related to health and safety, infection control and hazard management.

The nurse manager ensures all policies are current. Obsolete policies are filed electronically at organisational level. All policies sighted are up to date and meet best practice and legislative requirements.

Staff meeting minutes identify that key components of service delivery are a standing agenda item. Information is linked to organisational quality management systems and recorded via Amrisk. Information is benchmarked against other Metlifecare facilities and printed in the 'MET bulletin' which is available to staff, residents and family/whanau. If the benchmarking comparisons are outside the organisation's required norms monthly reports identify what corrective actions are being undertaken to improve any given situation until the matter is resolved. (All trended data is reporting using 1000 occupied bed days).

Staff and meeting minutes sighted identify that new risks are discussed and that corrective actions are put in place as required. Risks and potential risks (including clinical risks) to residents, staff and visitors are actively managed and monitored by the health and safety committee. Risks are identified in a risk register and corrective action planning is monitored at facility and organisational level. The risk register shows the measures put in place to eliminate, isolate or minimise all risks are appropriate to the services provided. The hazard register is kept in the nurses' station for easy access for all staff. Health and safety including any newly identified risks is a standing agenda item on staff meeting minutes.

Interviews with nine of nine staff confirm their understanding and input into quality systems.

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: 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 1.2.3.9 (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 Open Disclosure policy identifies that residents and their family/whanau have the right to know what has happened to them and to be kept fully informed.

Interviews with management confirm they report all untoward events at organisational level and to the appropriate statutory and/or regulatory bodies as required. This reporting process is maintained to meet tertiary level workplace safety management practices.

Metlifecare Coastal Villas ensure adverse events are recorded on incident and accident forms and that the information is used to improve services when required. Incidents and accidents are entered into Amrisk and data is benchmarked against other Metlifecare facilities.

A review of six residents' files (four hospital and two rest home) incident and accident reporting, confirm the forms are completed to show corrective actions are taken as appropriate. Incident and accident events are discussed at monthly staff and management meetings as confirmed in minutes sighted. Family/whanau reporting is clearly documented on each form sighted. One example related to the incorrect use of transdermal pain patches. Corrective actions sighted include informing the family/whanau, discussion with the resident, staff education, making one nominated staff position accountable for this process, and re-auditing the process which identifies no more mistakes have been made. This action is now closed off by the nurse manager and the SRN.

Interviews with staff, residents and family/whanau confirm adverse events are discussed in an open and honest manner.

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: FA

Evidence:

All newly employed staff receive a comprehensive orientation to enable them to successfully achieve the responsibilities and objectives of their role, and to enable them to function effectively and safely as a team member. There is a checklist in place that is completed to identify staff orientation has been completed and reviewed after three months service and then annual reviews are to follow. Human resource management practices are undertaken to meet Metlifecare's policies which are reflective of good employment processes and meet the requirements of legislation. The completion of orientation is confirmed in the review of seven of seven staff files (the SRN, one RN, two caregivers, one cleaner, one laundry worker and the nurse manager).

Professional qualifications are validated for staff that require annual practising certificates as confirmed in documentation sighted. Five GPs, one podiatrist, the pharmacist, one physiotherapist, eight registered nurse (RN)s and one enrolled nurse (EN)'s current practising certificates are sighted.

The annual education calendar and educational content along with evidence sighted in staff files reviewed, identifies that staff receive the education and training they require to meet resident needs in an informed manner. Staff interviews confirm they are satisfied with the standard and level of ongoing education offered.

Interviews with four of four residents and four of four family/whanau members confirm that services are delivered in a manner to meet all their needs, wants and likes.

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: 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 1.2.8: 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 documented process at organisational level to determine safe staffing levels at all Metlifecare facilities.

A review of four weeks of rosters for Metlifecare Coastal Villa confirms staffing levels and skill mix is maintained to meet policy requirements. Staff replacements for sickness and/or annual leave are shown on the rosters sighted. All shifts are covered by a staff member who holds a current first aid certificate, and a registered nurse. The nurse manager ensures that there is a mix of senior and junior staff on all shifts.

Staff interviews confirm that staffing levels and skill mix allows all residents' needs to be met in a timely manner and that they have time to complete all tasks each duty. The nurse manager and SRN confirm that rostered staff numbers are adjusted to meet resident acuity levels.

Resident and family/whanau interviews confirm they have no issues with staffing numbers and report they are very satisfied with the standard of care provided.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Each stage of the service provision at Metlifecare Coastal Villas (Coastal Villas) 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 senior 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 residents' 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 senior 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 six 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 resident's GP.

A previous corrective action identifying a lack of co-ordination has been addressed. Evidence of a co-ordinated approach to care with clear guidelines that promote continuity of care is sighted in files (two rest home and four hospital) reviewed.

Family contact is documented in the family contact record. Evidence of this is sighted in files reviewed and verified by interview (one rest home and three hospital residents and three hospital resident's family/whanau). 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 senior registered nurse at Coastal Villas, 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.

The senior RN oversees the residents and is responsible for care planning. Residents are attended to by their GP of choice. A verbal handover from RN to RN occurs at the beginning of each shift and she then hands over to caregivers to ensure all staff is familiar with the resident needs. 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. The facility's contracted GP visits every Thursday. There is a monthly multidisciplinary team meeting with the visiting psychogeriatrician, GP and physiotherapist and a monthly 'wound review' meeting.

Residents' notes are integrated and demonstrate input from a variety of health professionals, and are responsive to the ongoing 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 residents' files, where specialist input is required.

The ARRC contract requirements are met.

Tracer methodology one – Hospital resident

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

Tracer methodology two – Rest home resident

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 1.3.5: 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:

A previous corrective action identified some residents' files had no documented interventions to manage identified risks. This has been addressed. Care plans are developed in consultation with the resident and/or family/whanau, document the resident's individual plan of care identified by initial and on-going individual assessments, and describes the required support to enable the resident to meet their needs and achieve safe outcomes for residents with identified risk.

Residents have one set of clinical notes in which all providers involved with the resident's care use to document the resident's progress.

Evidence of the care provided is sighted as being documented by caregivers, registered nurses, activities officer, GP, allied health and specialist care providers. Progress notes, activities notes, medical and allied health professionals notations are clearly written, informative and relevant to the care provided. Any change in care required is either written or verbally passed on to those concerned and if implemented is documented in progress notes, communication book, handover sheet and the resident's care plan.

Care plans are evaluated six monthly or more frequently as the resident's condition dictates. Short term care plans, document the existence of short term problems and the required intervention.

Information from the assessment process informs the allied services of residents' needs. The kitchen is informed of need regarding nutrition, activity assessments inform the activities officer of interventions required in the activities programme, the physiotherapist is informed of any need for physiotherapy input and the podiatrist is informed if podiatry services are required. Additional input from other services may be requested if the assessment process identifies a need. Evidence of this is sighted in files reviewed.

Resident and family interviews, verify they are included in the planning of their care.

The ARRC requirements are 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:

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 services at Coastal Villas are delivered in a safe and respectful manner. A previous corrective action found not all assessments findings congruent with the interventions shown in the care plans, has been addressed. The provision of care is consistent with resident's desired outcomes in files reviewed. Interventions are detailed, accurate and meet best practice standards.

Interviews with the GP, residents and family/ whanau express satisfaction with the care provided.

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:

The activities programme at Coastal Villas is provided by a trainee diversional therapist who is mentored by a visiting diversional therapy educator. 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. Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate.

Individual activity assessments are updated or reviewed at least three monthly with a monthly summary of the residents response to the activities, level of interest and participation recorded. The goals are developed with the resident and their family, where appropriate.

A residents meeting is held monthly by the activities co-ordinator and the facility manager, and meeting minutes evidence that the activities programme is discussed and the residents are satisfied. The yearly resident/relative satisfaction survey also captures feedback on the activities programme and identifies a request for a wider range of activities to be provided. The manager verifies the activities coordinator is to be provided with an opportunity to visit other facilities and get ideas to allow for a more diverse range of 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 residents' 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 six monthly or as needs change. Evaluation measures the degree of achievement or response of each resident related to their goals six monthly. A previous corrective action identified where progress is different from expected the service did not always initiate changes. This has now been addressed. Where progress is different from expected, the service responds by initiating changes to the service delivery 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 senior RN undertakes and documents all care plan evaluations, at least every six months. 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 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 Douglas Pharmaceuticals Medico Pak delivery system. A previous corrective action identifying medication packs not being checked against the prescription for accuracy prior to being administered has been addressed. 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 a separate locked cupboard. Controlled drugs, when dispensed are checked by two medication competent staff (one a RN) for accuracy in dispensing. The controlled drug register evidences weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded.

The records of temperature for the medicine fridge have readings documenting temperatures 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 two residents who self-administer their medicines at the time of audit. The sighted assessments for self-administration are in these files reviewed and meet the facility's policy.

Medication errors are reported to the RN, recorded on an incident form, investigated and analysed. Incident forms recording medication errors are sighted and evidence provided supports appropriate action and follow up is occurring. The resident and/or the designated representative are advised.

The manager monitors to ensure all staff who administer medications have current competencies. RNs are assessed for medication competency yearly and approved senior healthcare workers are certified as competent in medication administration in the rest home and checking control drug dispensing and administration (documentation sighted), under the direction and delegation of a RN.

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

The 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 Coastal Villas is provided by an external provider in line with recognised nutritional guidelines for older people as verified by the dietitian's 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. The kitchen at Coastal Villas has an A+ grading certificate by the Kapiti County Council for hygiene standards.

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 resident's nutritional needs are sighted.

Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, as sighted in satisfaction surveys and resident meeting minutes.

There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed, as sighted and roster reviewed. The dining rooms are clean, warm, light and airy to enhance the eating experience.

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.

A previous corrective action identified a fridge located in the resident's dining room did not have the required daily temperature check and the food and fluids in that fridge were not covered or dated. This has been addressed. All fridge, freezer, and cooked meat temperatures are monitored daily. Records sighted verify records within accepted parameters. All food and drink is covered and dated.

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

Checking of electrical equipment has been undertaken and all new residents have all electrical appliances checked upon admission. This was an area identified for improvement in the previous audit and is now fully attained.

Documentation and interviews with management confirm all maintenance issues are followed to maintain a safe environment. The facility has a current building warrant of fitness which expires on 14 March 2015.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Policy and procedures are in place to ensure any restraint use is actively minimised. Policy identifies enablers are voluntarily used by a consumer following appropriate assessment. The service has seven enablers and seven restraints currently in use which are all bedside rails. The restraint register identifies when restraints are commenced and when they are stopped if no longer required.

Staff interviews confirm their knowledge and understanding of safe 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.)*

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

This was an area identified for improvement in the previous audit and is now fully attained. Evaluation of restraint is used to identify if desired outcomes are achieved. Documentation sighted identifies that all restraint is evaluated and that the GP reports on restraint use in medical reviews. Two files were reviewed related to restraint use and confirm that all aspects of restraint evaluation are clearly documented. No incidents have been recorded for residents with restraint in place. The SRN, who is the restraint coordinator, verbalises an in-depth understanding of safe restraint use and evaluation processes.

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:
(a) Future options to avoid the use of restraint;
(b) Whether the consumer's service delivery plan (or crisis plan) was followed;
(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);

(d) Whether the desired outcome was achieved;
(e) Whether the restraint was the least restrictive option to achieve the desired outcome;
(f) The duration of the restraint episode and whether this was for the least amount of time required;
(g) The impact the restraint had on the consumer;
(h) Whether appropriate advocacy/support was provided or facilitated;
(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
(j) Whether the service's policies and procedures were followed;
(k) Any suggested changes or additions required to the restraint education 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.)*

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 Coastal Villas infection control (IC) policy and procedures, monthly surveillance is occurring. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form. Incidents of infections and infection audit results are presented each month to the staff meeting and RN meeting and any necessary corrective actions are discussed. These are collated each month and analysed to identify any significant trends or possible causative factors. Any immediate infection concerns are addressed at handover and a

message alerting all staff to this concern is passed on electronically when the staff arrive for their shift. A yearly comparison based on previous incidents is used as a comparison if required. Any actions required are implemented.

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.)*