

# Melody Enterprises Limited

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## Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of 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).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Melody Enterprises Limited
<b>Premises audited:</b>	Rhapsody Rest Home and Private Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 10 December 2014    End date: 11 December 2014
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	68

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

## General overview of the audit

Rhapsody Rest Home and Private Hospital is located in an inner city suburb in New Plymouth. It provides rest home and hospital level care for up to 70 people. On the days of the unannounced surveillance audit there were 68 residents – 47 receiving rest home level care and 21 receiving hospital level care. Two large rooms are double rooms although only one was occupied by two residents at the time of this visit.

Two of five areas for improvement identified at the facility's certification audit in 2013 are now resolved, however three remain open and still require attention. A further seven were identified, totalling ten areas for improvement identified at this event. A number of these were due to the organisation's systems not being implemented as described in its quality management system. The week following the audit visit the facility manager resigned.

## Consumer rights

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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Residents and family/whanau interviewed reported that they received timely information and effective communication. When events occur family/whanau were notified as had been arranged and were kept informed of changes in a resident's wellbeing.

The organisation's complaints process was available and accessible throughout the facility. It complied with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights. There was a complaints register which was maintained by the administrator and the facility manager, and this was up to date when reviewed during the audit. Residents and family/whanau interviewed reported that they know how to make a complaint or raise any concerns so that they are addressed.

## Organisational management

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 medium or high risk and/or unattained and of low risk.
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Rhapsody Rest Home and Private Hospital is part of the Ultimate Care Group. The governing body is run out of a central office in Wellington with a chief executive officer. The facility manager reports to a regional manager based in Wellington, and is responsible for the operational management of the facility. There is a clinical services manager, who reports to the facility manager and who also has oversight from the Group's chief clinical officer who is based in Wellington. In this way the local management of the facility is monitored by the wider organisation.

There was an annual quality and risk management plan based on a generic template for the organisation. Staff members understood their responsibilities for quality management and adverse event reporting; however, there were four areas requiring improvement identified in relation to quality and risk management.

Human resources management was undertaken by the manager with support from the administrator. Personnel files, recruitment, selection and appointment have been continuing as described in the organisation's systems. Those staff members and contractors who hold practicing certificates have these validated and traced and all were current at the time of the audit. Training has been occurring but not to the breadth required by these standards or the contract for services and this needs to be addressed.

There was a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery, that was based on best practice. Staff interviewed were happy working at the facility and showed commitment to the residents' care and wellbeing.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents at Rhapsody Rest Home and Private Hospital had their needs assessed on admission, and the care required was identified, co-ordinated, planned and reviewed in participation with the resident. At times this was not always carried out by the registered nurse and this requires improvement. A previous required improvement related to care planning had yet to be addressed, and in addition, improvements were required to ensure care plans described the required support and interventions to meet residents' need.

An activities programme, that included a wide range of activities and involvement with the wider community, was enjoyed by residents of Rhapsody Rest Home and Private Hospital. The activities provided are designed to develop and maintain the strengths of residents, addressing a previous area requiring improvement.

Well defined medicine policies and procedures guided practice. Practices sighted were consistent with these documents; however, an area of improvement was required around prescriber documentation.

Menus were reviewed by a dietitian as meeting nutritional guidelines for older people. Any special dietary requirements and need for feeding assistance or modified equipment was recorded and was being met. Residents had a role in menu choice and those interviewed were satisfied with the food service provided.

## Safe and appropriate environment

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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The building has a current building warrant of fitness which expires on 21 January 2015. There have been no alterations to the building since the last on site audit.

## Restraint minimisation and safe practice

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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The facility has implemented a process of restraint minimisation for residents that was consistent with its policy. The service has maintained a process to determine approval for all types of restraint as well as enablers. This was supported by documentation with assessment, evaluation and monitoring of use of equipment. Meeting minutes demonstrated attempts to reduce the use of restraints where possible.

## Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Surveillance of infections was occurring at Rhapsody Rest Home and Private Hospital according to the descriptions of the process in their infection control programme. Data on the nature and frequency of identified infections was collated and analysed. Surveillance results were reported through all levels of the organisation, including governance.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	11	0	1	6	0	0
<b>Criteria</b>	0	32	0	1	9	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The Ultimate Care Group have a complaints policy and procedure which complied with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The procedures have been implemented at Rhapsody Rest Home and Private Hospital (Rhapsody) and copies of the complaint form were seen at accessible places throughout the facility. Information about the Code was also available for residents and family/whanau.</p> <p>The facility manager and office administrator maintained a hard copy complaint register and the organisation's electronic register through the 'GOSH' system which records all exceptions to service delivery. Both systems were current and demonstrated that complaints had been responded to and managed as is required by Ultimate Care Group's policy and the Code.</p> <p>A resident and family/whanau satisfaction survey had been completed during 2014 and the majority of responses confirmed that the process was available and known to residents. Staff members interviewed demonstrated their understanding of the organisation's system and their role in supporting residents or family/whanau to make complaints. Complaints was included as a topic in the training schedule which has been delivered in the last 12 months at the facility.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Incident, accident and other event reports reviewed recorded the communication of information to residents and family/whanau when this had been requested. Additional records confirmed that open disclosure was practised.</p> <p>Residents interviewed reported that staff communicated openly and clearly with them. Family members confirmed that they were contacted when falls and other incidents had occurred and staff members kept them informed. One family member commented on the prompt communication they had received and that this gave them a sense of confidence that their family member was in a safe place.</p> <p>Staff members interviewed discussed the importance of communicating with residents in ways they can understand and ensuring their understanding. Alternative supports (eg, interpreter services) can be accessed when needed. References were included in the organisation's policy and procedure documents.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Rhapsody Rest home and hospital is part of the Ultimate Care Group. There is a CEO based in the Head office in Wellington and a central office staffed with an executive management team including a chief clinical officer and general managers of human resources and finance. There is a regional management structure and the facility manager reports to one of the managers in this position. All facilities in the group have an annual business plan which was developed in 2013 for the 2014 calendar year and aligns to the organisation's goals to provide the best quality care and a home like environment. An annual quality and risk management plan is also developed to a consistent template, and tailored to each facility, by each facility manager (FM) for each calendar year. Both documents were reviewed with the FM and the chief clinical officer (CCO).</p> <p>A range of clinical and quality indicators are monitored through a weekly report system. This includes clinical indicators: falls, pressure ulcers, skin wounds, bruises, behavioural incidents, infections, drug errors, near misses, incidents, accidents, weight loss and sentinel events, as well as non-clinical indicators: complaints, property, security, emergency incidents, staff injuries, in-service training and attendance, staff appraisals, induction and orientation of new staff, entry and exit numbers, agency hours. The FM completes a weekly report to her regional manager and submits this electronically. This is then combined by the regional manager so that a consolidation across the group occurs.</p>

		<p>The FM reported at interview that she and her regional manager (RM) talk on a weekly basis when she has submitted her report. At interview with the RM she confirms that she is currently visiting the facility each week, and telephones each day. During the weekly visit the weekly report is reviewed along with the indicators, occupancy and progress against the business plan goals.</p> <p>The FM has a position description which outlines the responsibilities the role. These include recruitment, selection and appointment of staff, quality management systems, oversight of health and safety, maintenance and the physical building and systems, and training and development for all staff within the facility.</p> <p>The facility has a clinical services manager (CSM) who has been in the facility for four weeks at the time of the audit. He is an experienced registered nurse (RN), who worked for Ultimate Care Group previously and left to complete his post graduate diploma in gerontology. His position description describes the responsibilities of the role as being all clinical nursing decisions and for the performance of those staff members who hold health qualifications (registered and enrolled nurses) on staff at Rhapsody.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>Ultimate Care Group has an organisational quality and risk management system. Each facility is required to develop an annual quality and risk management plan to guide their activities for each calendar year, based on a generic template. The current Rhapsody plan for 2014 was reviewed with the facility manager. It relied largely on the generic template provided by the organisation and did not reflect individual quality initiatives for Rhapsody. For example, the quality projects included in the plan were 'business-as-usual' activities which were directed to occur regularly within the wider quality management system. The organisation's chief clinical officer, who was on site during the audit, reported that the organisation was going through a process of giving more direction to each manager as they developed their quality plan for 2015, to improve consistency and quality of plans across the organisation. However the draft 2015 plan was not available during the unannounced surveillance audit.</p> <p>There is an Ultimate Care Group - Clinical Advisory Group in place that comprises three clinical services managers, one facility manager, the regional managers, the chief clinical officer, and the clinical support and interRAI practitioner. The Clinical Advisory Group was responsible for reviewing clinical issues and events which have occurred and for the review and updating of all organisational policies and</p>

	<p>procedures, following feedback from each of the Ultimate Care Group sites. Evidence of the regular Clinical Advisory Group meetings was reviewed onsite which confirmed that this process occurred regularly and met the requirements of the standard. All documents seen during the onsite audit were current at the time of their use and sourced using the wider organisation's electronic systems for obtaining up to date documents.</p> <p>A range of staff members in the facility were interviewed and monthly reports which had been prepared for the quality group during the year were reviewed. These interviews and reports demonstrated that staff members understood their roles and responsibilities in the quality and risk management system. They knew that the quality committee meetings occurred and expressed a desire to receive information from these meetings. (See also adverse event reporting 1.2.4). Internal audits were occurring as scheduled by the organisation's central office. Each facility was prompted to complete these monthly through the GOSH system. Staff members in each area have delegated responsibility to complete audits relevant to their area and responsibilities. Sampling of the internal audits demonstrated that these were occurring. However, there was no collation of results of internal audits across the organisation, and little follow-up or identification of any issues.</p> <p>Improvement was required in relation to three quality management criteria under this standard and the risk management standard. The facility manager was interviewed and minutes of monthly quality committee meetings were reviewed. Review of the minutes and associated documents indicated little meaningful activity and decision-making took place during these meetings. The meetings involved reading out Clinical Advisory Group meeting minutes and memos, discussion of some individual events which had occurred during the month and the statistics for the past month, without analysis of the data. The quality committee was made of only two members – the facility manager and the clinical services manager with the office administrator as the minute taker. The organisation's terms of reference for quality groups outlines a wider membership with representation from each area in the facility. (See criterion 1.2.3.5). The facility manager interviewed had a lack of understanding of the purpose of the quality and risk management plan. There was no evidence in the quality committee minutes, staff meeting minutes or from a telephone interview with the regional manager that there was any process for measuring progress against the facility's quality and risk management plan.</p> <p>A previous area requiring improvement from the certification audit in 2013 required corrective action plans to be developed. Through the Clinical Advisory Group, the organisation has developed a process for corrective action plans to be</p>
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		<p>automatically generated when events are completed through the GOSH electronic system. The same corrective action plan document is available to be used whenever needed in a facility in response to areas for improvement which are identified through internal audits, complaints, trend analysis (if this is occurring) and for any other appropriate reason. Examples of this process were seen at Rhapsody. The facility manager reported that she had been directed to use the corrective action plan process by the regional manager and other head office support staff. This has addressed the previous issues; however, in most examples sighted the corrective action plans were signed off soon after they were developed and there was little monitoring of the implemented action to ensure the issue had been effective.</p> <p>There was a Group wide template risk management plan within the quality management system which provided a comprehensive range of risks with mitigation activities for use across the Group. Additional site specific risks can be added as needed by each facility manager. The plan presented for review during the interview was the generic Ultimate Care Group plan. During the interview the facility manager did not demonstrate an understanding of risk management practice or activities involved in monitoring risks.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>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.</p>	<p>FA</p>	<p>Ultimate Care Group's policies and procedures incorporated essential notification to the appropriate authorities when this was required. All incidents, accidents and events were recorded in the electronic GOSH system which involved notification to the Group's head office. The chief clinical officer and / or regional manager ensured that the local facility manager has made any necessary essential notifications.</p> <p>The incident, accident, and event log was reviewed with the manager. Staff reported all types of events as required by the organisation's systems and at interview were able to describe the system. They demonstrated a sound knowledge of the reasons for reporting events and their responsibilities for supporting residents if an event occurred. The electronic system required that the facility manager or clinical services manager reviewed and signed off each event in the GOSH system. This system also allowed for access to the data at the Group's head office for analysis of events at a local level by the clinical services manager and the chief clinical officer to review trends at an organisational level. (Refer required improvements at 1.2.3.6)</p> <p>During interviews with residents and family/whanau, they reported that staff</p>

		<p>members were very responsive when events had happened, providing assistance as quickly as possible and appropriate support. Family/whanau reported that they were notified as they had requested and were advised whenever events happened. The satisfaction survey results confirmed that both residents and family/whanau were mostly satisfied or very satisfied with the response to unexpected events.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>All health professionals who worked at the facility (employed and contracted) have their practicing certificates (APCs) monitored. Records of the nursing staff (enrolled and registered), the general practitioners, the physiotherapists, podiatrist, pharmacist and dietitian are all maintained by the office administrator. A selection of staff members APCs reviewed were current.</p> <p>Ultimate Care Group's human resources management procedures were utilised at Rhapsody. A large proportion of the staff have worked at the facility for a long time. Of those employed more recently review of their personnel files demonstrated that the organisation's systems for the selection and appointment of staff members to safely meet the needs of residents had been followed.</p> <p>Personnel files demonstrated that the induction and orientation process had been completed. At interview new staff reported that this had been completed by the office administrator and their immediate team leader, or as in the case of the clinical services manager, a manager from elsewhere in the Ultimate Care Group or the head office had undertaken his orientation. There was a file checklist which recorded the completion of the recruitment and appointment process. Like the personnel files, these were maintained by the office administrator, were current and accurately reflected completion of all relevant processes for each personnel file sampled.</p> <p>There was a mandatory list of training topics to be run annually in each facility within the human resources policies and procedures. A training folder has been maintained which included this list and the training that had been undertaken during the year, by month. The training delivered at Rhapsody was one third of the required mandatory training.</p> <p>Records of attendance at the in-service training sessions held were reviewed. Staff interviewed confirmed that this training was run and that they enjoyed attending the in-service education sessions and the process of learning in a group.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The manager completed the Ultimate Care Group rostering tool on a weekly basis. This has been designed to ensure that the staff skill mix meets the assessed needs of residents. The roster was reviewed by the regional manager and variations to the approved ratios of staff to residents must be approved by the regional manager. A consolidated report goes to the organisation's chief executive officer.</p> <p>The rosters for the current week were reviewed with the facility manager and the chief clinical officer. There was an appropriate number of staff and an appropriate mix of staff (registered nurses and caregivers) across the shifts to safely meet the needs of residents. In addition, there were sufficient numbers of support staff members in catering, household, administration, maintenance and activities to provide these services to residents at Rhapsody.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Medicines for residents at Rhapsody were received from the pharmacy in the robotic delivery system. A safe system for medicine management was observed on the day of audit. All staff who administered medicines had current medication competencies (sighted) which was assessed yearly; this was managed by the clinical services manager. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management.</p> <p>Controlled drugs were stored in a separate locked cupboard. Controlled drugs, when administered were checked by two nurses for accuracy in administration. The controlled drug registers evidenced weekly stock and quantitative checks, six monthly pharmacist checks and accurate records.</p> <p>No evidence was provided to show that the temperatures for the medicine fridge were within the recommended range.</p> <p>The medicine prescription was signed individually by the GP. The GP's signature and date was recorded on the commencement and discontinuation of medicines. Residents' photos, allergies and sensitivities were recorded on the medicine chart. Sample signatures were documented. Not all medicine charts reviewed had fully completed medicine prescriptions. All had signing sheets including approved abbreviations when a medicine had not been given. The three monthly GP review was recorded on the medicine chart.</p> <p>There were residents who self administered their medicines at the time of audit and evidence was sighted of non compliance with safe drug self administration</p>

		<p>protocols (refer 1.3.6.1).</p> <p>Medication errors were reported to the clinical services manager and recorded on an incident form. The resident and/or the designated representative were advised. A review of drug error management processes verified these were being managed appropriately.</p> <p>Standing orders are not used at Rhapsody. Any pro re nata (PRN) (as required) medication administered required authorisation on the resident's medication chart. PRN medication requests included indications for use as confirmed in 20 charts sighted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food, fluid and nutritional requirements of the residents were provided in line with recognised nutritional guidelines.</p> <p>Food preparation and handling was in line with safe food handling guidelines. The effectiveness of chemical use, cleaning, and food safety practices in the kitchen was monitored by an external provider. The facility received monthly reports and recordings on the effectiveness of the programme. A cleaning schedule was sighted as was verification of compliance.</p> <p>A dietary assessment was 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 were known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted.</p> <p>Evidence of residents' satisfaction with meals was verified by resident and family/whanau interviews, sighted satisfaction surveys and residents' meeting minutes.</p> <p>There were sufficient staff seen to be on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed. This was also confirmed in rosters reviewed. The dining rooms were clean, warm, light and airy to enhance the eating experience.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer</p>	<p>PA Moderate</p>	<p>The care plan was developed in consultation with the resident and/or family/whanau and described the required support the resident needed to meet</p>

<p>focused, integrated, and promote continuity of service delivery.</p>		<p>their goals and desired outcomes in six of ten files reviewed. Residents had one set of clinical notes in which all providers involved with the resident's care documented the resident's progress. Short term care plans documented the existence of short term problems and the required intervention.</p> <p>Evidence of the care provided was sighted. Progress notes, activities notes, medical and allied health professionals notations were clearly written, informative and relevant to the care provided. Any change in care required was either written or verbally passed on to those concerned and if implemented was documented in progress notes and the resident's care plan. Care plans were evaluated three monthly or more frequently as the resident's condition dictated. Evidence of this was sighted in files reviewed. Resident and families interviewed verified they were included in the planning of their care.</p> <p>The staff education records sighted demonstrated that staff received appropriate training with some exceptions (refer 1.2.7.5).</p> <p>Staff were observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit. The facility has access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures. Timely access to other health providers was evident in residents' files, where specialist input was required.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Files reviewed, observations and interviews verified the provision of care provided to residents was at times inconsistent with residents' physical, social, spiritual and emotional needs and desired outcomes. Interventions were detailed, accurate and met current best practice standards in six of ten files reviewed (refer 1.3.5.2)</p> <p>Interviews with residents and family/whanau members expressed satisfaction with the care provided.</p> <p>There were sufficient supplies of equipment that complied with best practice guidelines and met the residents' needs (sighted).</p> <p>An interview with the general practitioner (GP) verified satisfaction with the service provided by Rhapsody. Staff requested appropriate medical input and responded in an appropriate and timely manner to the GP's requests.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	<p>FA</p>	<p>A planned activities programme at Rhapsody was sighted that facilitated the residents' developing and maintaining their strengths and interests as identified in the admission assessment. The activities provided are designed to develop and maintain the strengths of residents, addressing a previous area requiring improvement. The programme reflected ordinary patterns of life and included community and family involvement where appropriate. Individual activity assessments were 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 were developed with the resident and their family, where appropriate. Residents interviewed and observed expressed pleasure and enthusiasm for the activities on offer at Rhapsody</p> <p>The activities programme was provided by a trained diversional therapist in addition to a trainee diversional therapist, both with current first aid certificates. Photographs around the facility offered insight into the events that have taken place.</p> <p>A residents' meeting was held monthly and was run by the activities staff, the administrator and the visiting chaplain. Meeting minutes evidenced satisfaction with the activities programme as did residents and family interviews. The activities personnel (interviewed) reported feedback was sought from residents during and after activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care was evaluated daily and reported in the progress notes. If any change was noted it was reported to the RN or EN.</p> <p>Formal care plan evaluations measuring the degree of a resident's response in relation to desired outcomes and goals occurred every three months or as resident's needs changed and were carried out by the RN or EN. Where progress was different from expected, the service was seen to respond by initiating changes to the service delivery plan. A short term care plan was initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans were reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.</p> <p>Evidence of evaluation was sighted in files reviewed. Resident and family interviews verified they were included and informed of all care plan updates and changes.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There was a current building warrant of fitness on display at Rhapsody. This expires on 21 January 2015. All of the building's systems, plant and equipment were regularly monitored by a local contractor and were checked at the annual warrant of fitness check.</p> <p>There have been no alterations to the building since the last onsite audit.</p> <p>The environment has been purpose built, with wide corridors, handrails throughout and non-slip flooring or easy-glide carpeting. There were easily accessible areas outside the building throughout the facility. During the audit residents were seen moving about independently, with assistance and using mobility equipment.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>PA Moderate</p>	<p>On the day of audit the recently appointed clinical services manager had been in his position for three and a half weeks. He had identified that the role of infection control coordinator had been assigned to a staff member who has not had recent (ie: within the last 12 – 18 months) specific training in this area. He had taken on the role himself in order to better understand the issues in the facility, but his own infection control training was last completed three years ago.</p> <p>At interview with a group of staff members from across the facility they report that basic hand hygiene is included in their induction and orientation programme and also, for support workers, in the ACE training for those who complete these certificate courses. As noted under standard 1.2.7 personnel files are kept in good order and indicate that the records available are complete. This indicates that insufficient training has been scheduled for staff to attend to meet the requirements of this standard.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>In line with the infection control (IC) policy and procedures, monthly surveillance was occurring at Rhapsody. The type and frequency of surveillance was determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month were recorded on an infection report form. These were collated each month and analysed to identify any significant trends or possible causative factors. Incidents of infections were presented at the quality, RN and staff meetings every month. A yearly comparison based on previous incidents was used as a comparison to</p>

		<p>analyse trends. Any actions required were presented to staff at staff meetings and any necessary corrective actions discussed, as evidenced by meeting records, IC records and verified by staff interviewed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Ultimate Care Group had a range of policies and procedures which made up its restraint minimisation and safe practice system. These included an emphasis on the minimisation of the use of restraint and promoting independence and safety. Enablers were used for people who were able to consent to the use of equipment which promoted safety and independence.</p> <p>There was a process for the assessment of a resident needing to use equipment. This included appropriate consent processes, monitoring of the use of the equipment and review. A register was maintained which recorded those residents who were using restraints or enablers.</p> <p>During the onsite audit the CSM was interviewed. At the time of the audit he was the restraint coordinator. Although he had only been at Rhapsody a short time he had already reviewed the files and restraint or enabler documentation for all the residents on the register. He demonstrated a sound knowledge of both the Ultimate Care Group's system for restraint minimisation and of those residents using equipment.</p> <p>Two residents were using enabling equipment at the time of audit in the way of bed rails. Both have requested the bed rails, and their files and documentation reviewed recorded that using the rails meant they felt safe and could move independently in bed. Both had a current consent and the register showed the date of their next review.</p>

## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	<p>PA</p> <p>Moderate</p>	<p>Internal audits, defined through an automated system from Ultimate Care Group head office were completed by staff members in the facility. However, there was no meaningful analysis of the results of these audits, collation of results across the facility and comparison of results of audits over time.</p> <p>Although the recently appointed clinical services manager has demonstrated an understanding of his role and responsibility for quality management in the meetings he has attended, such a minimal committee membership of two people is a risk to the facility and does not provide an inclusive environment for sharing knowledge, decision-making, and</p>	<p>Internal audits are completed by staff as required, however the manager’s responsibilities for analysis of the results and monitoring progress over time was not occurring.</p> <p>Although there have been monthly quality committee meetings, and staff are reporting incidents, the data from event reports has not been incorporated into the quality management system in a meaningful way. See also the finding against criterion 1.2.3.6.</p>	<p>Implement the organisation’s quality management systems, including the recommended membership of the quality committee, ensuring that there are linkages of key components within the system and effective implementation.</p> <p>90 days</p>

		understanding of the issues within the facility.		
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Moderate</p>	<p>There was evidence that regular quality committee meetings have been occurring and that a standard agenda was used for these meetings. Detailed reports were provided each month by the heads of each part of the facility which summarised the number of events which had occurred in each area, categorised them and gave details of actions taken to manage the individual events. In most cases these individual reports also included some assessments of trends or contributing factors.</p> <p>Although there was a document labelled corrective action plan with each set of quality committee minutes, the quality committee itself has not made any meaningful decisions, nor taken any action in response to events. Up until October and November 2014, the documentation reflected a lack of understanding by the members of the quality committee of the purpose of collating this data, analysing and evaluating data in the most rudimentary way.</p>	<p>There was no evidence that staff received feedback on summarised incident / accident data. There was no trend analysis occurring, and regular reports from each area within the facility which were provided each month were not used or acted on. Records of quality committee activity did not demonstrate that there had been any analysis or evaluation of quality improvement data since the last onsite audit.</p>	<p>Implement the organisation's quality management systems, in particular the analysis and evaluation of quality improvement data.</p> <p>90 days</p>
<p>Criterion 1.2.3.7</p>	<p>PA</p>	<p>There was no evidence of the quality and risk management plan</p>	<p>There was no evidence of a process being implemented to</p>	<p>Implement the organisation's system for measuring progress</p>

<p>A process to measure achievement against the quality and risk management plan is implemented.</p>	<p>Moderate</p>	<p>being monitored throughout the year in any way. Quality committee minutes from 2014 were reviewed and these contained no references to reviews of the quality plan. The current regional manager has only had oversight of this facility for the last few months prior to this surveillance audit and she reports that management and operational issues have been her priority.</p>	<p>track and measure the progress and achievement of the quality and risk management plan.</p>	<p>against the facility's quality and risk management plan.</p> <p>90 days</p>
<p>Criterion 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.</p>	<p>PA Moderate</p>	<p>The risk management plan provided on the day of audit was the generic plan provided by the Ultimate Care Group. The intention was that each facility add to this plan as relevant to their facility. There was no evidence that this had occurred. At interview the manager did not demonstrate an understanding of risk management practices or the Ultimate Care Group's risk management systems.</p> <p>While most risk management and mitigation activities were occurring as planned, the plan itself could not initially be found and when found was altered during the audit.</p>	<p>There was limited risk management activity occurring at the time of the onsite audit. In particular monitoring and analysis of whether risk mitigation activities were in place and were effective for the Rhapsody site.</p>	<p>Implement the organisation's system for risk management in its entirety to ensure that business risks are being appropriately managed.</p> <p>90 days</p>

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>Records of attendance at the in-service training sessions which have been held were reviewed. Staff interviewed confirmed that this training was run and that they enjoyed attending the in-service sessions. There has been good attendance by staff at the scheduled sessions. However, only one third of the mandatory training required by Ultimate Care Group had been run in the facility over the last 12 – 24 months.</p>	<p>Not all training required by these standards, the contracts with the District Health Board or as described in the organisation's policies and procedures for ongoing training and development had been scheduled and delivered. This was a required improvement from Certification in 2013 which has not yet been fully addressed. See also standard 3.4 Infection prevention and control.</p>	<p>A complete training schedule be implemented for 2015, and delivered in a way which is meets the learning needs of staff, as is described in the organisation's human resource management system.</p> <p>At interview with the new clinical services manager he reported that there has been no recent infection control training for the person appointed to this position in the facility.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>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.</p>	<p>PA Moderate</p>	<p>The request for a medication related to blood test results, did not identify the date it was started, nor give clear directions in regards to the required dosage (refer 1.3.6.1).</p> <p>Fridge temperatures for the fridge storing medication is not recorded.</p>	<p>Documentation on a medication charts did not ensure the medication can be administered safely and accurately. Storage of medication did not comply with protocols and guidelines.</p>	<p>A medicines management system is implemented to manage the safe and appropriate prescribing, in order to comply with legislation, protocols and guidelines. Fridge temperatures of the medication fridge are recorded to ensure the medications are stored at the correct temperature.</p> <p>90 days</p>
<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced</p>	<p>PA Moderate</p>	<p>Interview with the enrolled nurse (EN), and sighted documentation identified the enrolled nurse assessed and admitted some residents. Following the initial assessment the EN completed the initial care plan, ongoing</p>	<p>All residents at Rhapsody are not assessed, reviewed and evaluated by an RN as required in the service provider's agreement with the district health board.</p>	<p>Residents are required to be assessed, reviewed and evaluated by a registered nurse.</p> <p>90 days</p>

service providers who are competent to perform the function.		assessments, long term care plan development and ongoing care plan review and evaluations. Evidence of this was verified in five of ten files reviewed. This is an area requiring improvement as this does not meet contractual requirements or best practice.		
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	The care plan was developed in consultation with the resident and/or family/whanau and described the required support the resident needed to meet their goals and desired outcomes in six of ten files reviewed however four of ten care plans had no documentation to support the resident meeting the desired outcomes in relation to wound care, seizure management and insulin management.	Care plans did not always describe the required support to meet residents assessed needs.	<p>Care plans must identify the required support the resident requires.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Documentation in the files of four residents did not identify the specifics required to manage the residents' conditions (refer 1.3.5.2). A resident who wanted to self administer medication had no interventions documented to manage the identified risks specific to this resident.	Intervention in care plans did not always meet residents assessed needs and desired outcomes	<p>Residents receive adequate and appropriate services to meet their assessed needs.</p> <p>180 days</p>

<p>Criterion 3.4.1</p> <p>Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.</p>	<p>PA Moderate</p>	<p>A complete training schedule be implemented for 2015, and delivered in a way which is meets the learning needs of staff, as is described in the organisation's human resource management system.</p> <p>At interview with the new clinical services manager he reported that there has been no recent infection control training for the person appointed to this position in the facility.</p>	<p>A complete training schedule be implemented for 2015, and delivered in a way which is meets the learning needs of staff, as is described in the organisation's human resource management system.</p>	<p>A complete training schedule be implemented for 2015, and delivered in a way which is meets the learning needs of staff, as is described in the organisation's human resource management system, including the provision of infection control training for all staff, and up to date infection prevention and control training for the infection control coordinator.</p> <p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.