

Ki-Chi Service Supplies Company Limited

Current Status: 4 November 2013

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

Raglan Trust Hospital and Rest Home is certified to provide hospital and rest home level care for up to 29 residents. On the day of the audit, there were 14 residents in the hospital and 12 residents in the rest home. The manager is a registered nurse who has been employed by this service for seven years. She has previous experience working in the aged care sector. There have been improvements to the environment since the previous audit including the maintenance of several fixtures and fittings in toilet and shower areas.

The service has fully addressed five of the ten shortfalls from their previous certification audit around residents and relatives input into the care planning process, GP documentation; wounds management; care plan evaluations; medication management, training in food safety; and integration of files.

Further improvements continue to be required to ensure all documents are dated; that assessments are completed for all relevant areas for all residents; that all identified residents' needs are accurately addressed in their care plan and to paint the swing bar in one toilet.

This audit identified additional improvements required relating to documenting evidence of open disclosure, trending and analysing quality data for service improvements, ensuring corrective actions are in place where opportunities for improvements are identified, ensuring the enrolled nurses holds a current practising certificate; ensuring staff administering medicines are competent to perform the task; ensuring that all food and chemicals are stored correctly in the kitchen; a number of fixtures and fittings in toilets and shower areas require maintenance; ensuring all chemicals decanted are labelled; and servicing of two hoists.

Audit Summary as at 4 November 2013

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 |

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

Consumer Rights as at 4 November 2013

| | | |
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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Some standards applicable to this service partially attained and of low risk. |
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Organisational Management as at 4 November 2013

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of low risk. |
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Continuum of Service Delivery as at 4 November 2013

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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Safe and Appropriate Environment as at 4 November 2013

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | 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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Restraint Minimisation and Safe Practice as at 4 November 2013

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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Infection Prevention and Control as at 4 November 2013

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| <p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p> | | <p>Standards applicable to this service fully attained.</p> |
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HealthCERT Aged Residential Care Audit Report (version 3.9)

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: | Ki-Chi Service Supplies Company Limited | | |
| Certificate name: | Raglan Trust Hospital and Rest Home | | |
| Designated Auditing Agency: | HDANZ | | |
| Types of audit: | Spot Surveillance audit | | |
| Premises audited: | Raglan Trust Hospital and Rest Home ; 27-29 Manukau Road, Raglan | | |
| Services audited: | Hospital and Rest Home Services | | |
| Dates of audit: | Start date: 4 November 2013 | End date: 4 November 2013 | |
| Proposed changes to current services (if any): | | | |
| | | | |
| Total beds occupied across all premises included in the audit on the first day of the audit: | | | 26 |

Audit Team

| | | | | | |
|--------------------------|-------|----------------------------|---|-----------------------------|---|
| Lead Auditor | XXXXX | Hours on site | 9 | Hours off site | 5 |
| Other Auditors | XXXXX | Total hours on site | 9 | Total hours off site | 5 |
| Technical Experts | | Total hours on site | | Total hours off site | |
| Consumer Auditors | | Total hours on site | | Total hours off site | |
| Peer Reviewer | XXXXX | | | Hours | 1 |

Sample Totals

| | | | | | |
|--|----|-----------------------------------|----|--------------------------------------|----|
| Total audit hours on site | 18 | Total audit hours off site | 11 | Total audit hours | 29 |
| Number of residents interviewed | 4 | Number of staff interviewed | 10 | Number of managers interviewed | 1 |
| Number of residents' records reviewed | 4 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 28 | Number of relatives interviewed | 3 |
| Number of residents' records reviewed using tracer methodology | 2 | | | Number of GPs interviewed | 1 |

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

| | | |
|----|--|-----|
| a) | I am a delegated authority of the DAA | Yes |
| b) | the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | the DAA 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 has provided all the information that is relevant to the audit | Yes |
| h) | the DAA Auditing Agency has finished editing the document. | Yes |

Dated Tuesday, 26 November 2013

Executive Summary of Audit

General Overview

Raglan Trust Hospital and Rest Home is certified to provide hospital and rest home level care for up to 29 residents. On the day of the audit, there were 14 residents in the hospital and 12 residents in the rest home. The manager is a registered nurse who has been employed by this service for seven years. She has previous experience working in the aged care sector. There have been improvements to the environment since the previous audit including the maintenance of several fixtures and fittings in toilet and shower areas.

The service has fully addressed five of the ten shortfalls from their previous certification audit around residents and relatives input into the care planning process, GP documentation; wounds management; care plan evaluations; medication management, training in food safety; and integration of files.

Further improvements continue to be required to ensure all documents are dated; that assessments are completed for all relevant areas for all residents; that all identified residents' needs are accurately addressed in their care plan and to paint the swing bar in one toilet.

This audit identified additional improvements required relating to documenting evidence of open disclosure, trending and analysing quality data for service improvements, ensuring corrective actions are in place where opportunities for improvements are identified, ensuring the enrolled nurse's holds a current practising certificate; ensuring staff administering medicines are competent to perform the task; ensuring that all food and chemicals are stored correctly in the kitchen; a number of fixtures and fittings in toilets and shower areas require maintenance; ensuring all chemicals decanted are labelled; and servicing of two hoists.

Outcome 1.1: Consumer Rights

Processes for open disclosure and complaints management are in place. Families report they are kept informed. There is one required improvement. Evidence of open disclosure needs to be documented.

Outcome 1.2: Organisational Management

Raglan Trust Hospital and Rest Home has a quality and risk management system in place that is implemented and monitored, which generates improvements in practice and service delivery. The internal audit system to regularly assesses service performance.

Service operational plans, and policies and procedures are in place. Resident satisfaction surveys are completed and regular resident meetings are held. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status.

The orientation programme provides new staff with relevant information for safe work practice. Regular in-service education covers relevant aspects of care and support.

The staff roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Improvements are required to analyse quality data, to ensure corrective action plans are documented and implemented where opportunities for improvements are identified, and to ensure the enrolled nurse holds a current practising certificate.

Outcome 1.3: Continuum of Service Delivery

Service delivery is managed by registered nurses. Residents are assessed on entry to the facility by the care staff and initial plans of care developed. Residents are seen by their general practitioner within 48 hours of admission and are seen regularly thereafter or at least three monthly if their health is stable. Initial plans of care are developed by registered nurses and following a period of assessment a long term plan of care is developed. Care is evaluated formally every six months or earlier if a resident's needs change. Each resident has an individual activities plan and they are able to participate in a group activities programme if they choose to do so. Food is cooked on site and the residents who were interviewed were satisfied with the standard of food served. Improvements have occurred since the last audit with respect to documentation of care. However some previously identified improvements still need to be addressed and a number of further improvements were identified. Improvements are required to documentation. There is a need to ensure staff administering medicines are competent to perform the task and there is a need to ensure that all food and chemicals are stored correctly in the kitchen. .

Outcome 1.4: Safe and Appropriate Environment

The building has a current warrant of fitness. Improvements have been made in the maintenance of fixtures and fitting in toilets and shower areas. However further improvements are required to fixtures and fittings in these areas. An improvement is required to the way in which chemicals are stored. An improvement is required with respect to the servicing of two hoists.

Outcome 2: Restraint Minimisation and Safe Practice

Procedures are in place to ensure restraints are actively minimised and enablers such as bed rails are available on request by the resident. At the time of the audit, three hospital level residents were using bedrails as a restraint and no residents were using enablers.

Outcome 3: Infection Prevention and Control

Surveillance for infection occurs as part of the infection prevention and control programme and is described in policy and in the risk management plan which is developed annually. Monthly infection data are collected, monitored and evaluated. Outcomes and actions are discussed at staff meetings. Benchmarking occurs within the service and externally within the Cavell Group.

Summary of Attainment

| | CI | FA | PA Negligible | PA Low | PA Moderate | PA High | PA Critical |
|------------------|----|----|---------------|--------|-------------|---------|-------------|
| Standards | 0 | 10 | 0 | 6 | 4 | 0 | 0 |
| Criteria | 0 | 34 | 0 | 10 | 2 | 0 | 0 |

| | UA Negligible | UA Low | UA Moderate | UA High | UA Critical | Not Applicable | Pending | Not Audited |
|------------------|---------------|--------|-------------|---------|-------------|----------------|---------|-------------|
| Standards | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 30 |
| Criteria | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 55 |

Corrective Action Requests (CAR) Report

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|-------------------------------|---|------------|---|--|------------------|
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Three relatives (hospital level) state that they are kept informed when their family members health status changes. There is evidence of family being contacted on the accident incident forms following a fall where injury has been sustained, but there is a lack of evidence that family are kept informed following a minor adverse event (eg, skin tear). | Ensure families are kept informed of adverse events. | 180 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---|---|------------|---|---|------------------|
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The quality improvement data that is being collected (eg, falls, skin tears, infections, challenging behaviours, medication errors, infections) are collected with numbers provided to staff at staff meetings. There is a lack of evidence to reflect this data being analysed, evaluated and used for service improvements. | Ensure quality improvement data that is being collected is analysed and evaluated with the results communicated to staff. | 90 |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The manager signs off corrective actions when quality initiatives have been implemented (evidenced in three of three corrective action forms for 2013) but there is a lack of evidence of recommendations from internal audits being signed off when completed. | Ensure corrective actions resulting from internal audits are implemented and signed off when completed. | 90 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | | | |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|--|--|-------------|--|--|------------------|
| HDS(C)S.2008 | Criterion 1.2.7.2 | Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Low | Current practicing certificates were sighted for seven RNs (including the manager), three GPs, three physiotherapists and the pharmacist. The practising certificate for the enrolled nurse has expired. | The enrolled nurse needs to update her practising certificate. | 30 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | (i)Residents are not being weighed on the day of admission. Weights are not being recorded by date (only month and year is recorded). (ii) Long term care plans are not being developed, documented and evaluated by a registered nurse within three weeks of admission (D16.3). | (i)Ensure all newly admitted residents are weighed to establish baseline information. (ii) Ensure all residents have a permanent care plan developed, documented and evaluated by a registered nurse within three weeks of admission that contains links to other documentation in the clinical file so that the care plan fully guides the provision of care. | 30 |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.3.4.2 | The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | Initial care plans and assessments require evidence of registered nurse input and agreement in evaluating the initial care (D16.2 & D16.3c). | Ensure that each initial care plan contains evidence of registered nurse input and agreement. | 30 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|--------------------------------------|---|-------------|--|--|------------------|
| HDS(C)S.2008 | Standard 1.3.5: Planning | Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 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. | PA Low | (i)Service delivery plans do not describe the required support and interventions identified by the assessment process. (ii) Long term care plans do not guide care or contain links to other documentation included elsewhere in the clinical record. Additional instructions are not recorded on a short term care plan. (iii) The tracer resident who weighed less than 40 kgs and has lost more than 5kgs since January 2013 has no plan of action or explanation recorded. | Ensure each resident has a current service delivery plan that describes all required supports and/or interventions that they need to achieve their goals or desired outcomes. Ensure residents who are losing weight or gaining weight over time are reviewed medically and are actively managed if appropriate. | 30 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | The indication for PRN medicine orders is not always documented by the prescriber. | Ensure the prescriber of PRN medicines clearly indicates the rationale for the use of the PRN medicine. | 60 |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|---|--|-------------------|---|---|-------------------------|
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | All registered nurses who administer medicines have yet to be formally assessed as competent. | Ensure all staff who administer medicines demonstrate competency to a registered nurse who has demonstrated competency and that the assessment process and outcome is documented. | 30 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | | | |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Food storage practices for dried food are not consistent with safe food storage guidelines and all chemicals in use are not labelled. | Ensure food is stored appropriately according to safe food practice and that chemicals are stored in labelled containers. | 30 |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | | | |
| HDS(C)S.2008 | Criterion 1.4.2.4 | The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | Chemicals are in use and are not being stored safely in correctly labelled containers. Two hoists in use have not been serviced since October 2011. | Ensure all chemicals are stored safely in correctly labelled containers. Ensure hoists used to lift residents are serviced annually to minimise the risk of harm to residents. | 30 |
| HDS(C)S.2008 | Standard 1.4.3: Toilet, Shower, And Bathing Facilities | Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | PA Low | | | |

| Code | Name | Description | Attainment | Finding | Corrective Action | Timeframe (Days) |
|--------------|-------------------|--|------------|---|--|------------------|
| HDS(C)S.2008 | Criterion 1.4.3.1 | There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use. | PA Low | There are broken surfaces in toilets and shower areas that do not meet the needs of consumers, as the surfaces are not able to be easily cleaned. | Ensure maintenance issues are addressed and that all surfaces can be easily cleaned in line with infection prevention guidelines and minimise the risk of harm to residents. | 90 |

Continuous Improvement (CI) Report

| Code | Name | Description | Attainment | Finding |
|------|------|-------------|------------|---------|
| | | | | |

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Attainment and Risk: Not Audited

Evidence:

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Attainment and Risk: Not Audited

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 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Attainment and Risk: Not Audited

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 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Attainment and Risk: Not Audited

Evidence:

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Attainment and Risk: Not Audited

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 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Attainment and Risk: Not Audited

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 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Attainment and Risk: Not Audited

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 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Attainment and Risk: Not Audited

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 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Attainment and Risk: Not Audited

Evidence:

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Attainment and Risk: Not Audited

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 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: Not Audited

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 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Attainment and Risk: Not Audited

Evidence:

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Attainment and Risk: Not Audited

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 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Attainment and Risk: Not Audited

Evidence:

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 1.1.9: 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

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| Attainment and Risk: PA Low |
| Evidence: <p>There is an open disclosure policy that sets out what should happen in the event of an adverse event, when a resident has suffered any unintended harm while receiving care. The policy is based on the principle that residents' and their families have a right to know what has happened to them and to be fully informed as set out within the Code of Health and Disability Services Consumers' Rights.</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.</p> <p>D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b Three relatives (hospital level) state that they are kept informed when their family members health status changes. There is evidence of family being contacted on the accident incident forms following a fall where injury has been sustained, but there is a lack of evidence that family are kept informed following a minor skin tear.</p> |

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.

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| Attainment and Risk: PA Low |
| Evidence: <p>There is an open disclosure policy that sets out what should happen in the event of an adverse event, when a resident has suffered any unintended harm while receiving care. The policy is based on the principle that residents' and their families have a right to know what has happened to them and to be fully informed as set out within the</p> |

Code of Health and Disability Services Consumers' Rights.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b Three relatives (hospital level) state that they are kept informed when their family members health status changes. There is evidence of family being contacted on the accident incident forms following a fall where injury has been sustained, but there is a lack of evidence that family are kept informed following a minor adverse event (eg, skin tear).

Finding:

Three relatives (hospital level) state that they are kept informed when their family members health status changes. There is evidence of family being contacted on the accident incident forms following a fall where injury has been sustained, but there is a lack of evidence that family are kept informed following a minor adverse event (eg, skin tear).

Corrective Action:

Ensure families are kept informed of adverse events.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: Not Audited

Evidence:

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Attainment and Risk: Not Audited

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 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where required.

Attainment and Risk: Not Audited

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

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

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

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| Attainment and Risk: Not Audited |
| 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 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Attainment and Risk: Not Audited

Evidence:

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

Attainment and Risk: Not Audited

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 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when appropriate.

Attainment and Risk: Not Audited

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:

There is a complaints and advocacy policy in place. As per policy, 'issues must be resolved promptly in a sensitive and fair manner if a resident or their family has a genuine concern or complaint about the care or quality of life given to the resident'. The complaints process aligns with the requirements of the Code of Health and Disability Consumers' Rights.

Residents/family can lodge formal or informal complaints through verbal communication, written, resident meetings, and/or complaint forms.

Interviews with four residents (three rest home and one hospital) and three relatives (hospital level) confirm that they are familiar with the complaints procedure and state any concerns/complaints are addressed in a timely manner.

A complaints log/register includes the date the complaint was received, complainant, summary of complaint, date filed, signature. Twenty-four complaints have been lodged in 2013 (seven lodged by family, eight lodged by residents and the remaining lodged by staff). Five complaints lodged by residents and/or family were selected for review. All complaints documented included appropriate and prompt follow-up action(s) taken with sign-off by the manager.

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.

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

Outcome 1.2: Organisational Management

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: <p>The owners, who live in Auckland, purchased this facility as a limited liability company two years ago from Raglan Hospital Community Trust Board. The owners visit the facility on a weekly basis. The manager registered nurse (RN) reports weekly to the owners on a range of operational matters including strategic and operational issues, incidents and accidents, complaints, and health and safety.</p> <p>The Cavell Group maintains the quality systems, and standard operating procedures (eg, policies and procedures). The group consists of owners from seven aged care facilities in the Waikato and Bay of Plenty. The manager attends Cavell Group meetings three times a year (8 hours each) and receives additional support and mentoring when needed.</p> <p>Raglan Hospital and Rest Home has a documented philosophy for the service. A quality plan (January 2012 – January 2015) is in place, which lists strategic objectives for the service.</p> <p>The manager is a registered nurse with a current practising certificate. She has been employed by the facility for the past seven years and reports she has been working primarily in aged care since graduating from nursing school in 1994. The manager has recently taken on the role as the main clinical leader. A team leader (RN), who is a new graduate (New Zealand trained) nurse, provides additional clinical support.</p> |

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.

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

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

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

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

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

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| Attainment and Risk: PA Low |
| Evidence: <p>Raglan Home and Hospital is certified to provide rest home and hospital level care for up to 29 residents. On the day of the audit, there were 12 rest home level residents and 14 hospital level residents. Three rooms are currently decommissioned while renovations are underway, adding seven additional hospital level residents' rooms. Cavell Group policies and procedures guide the facility on implementation of the quality management programme. Elements of the quality system include a mission statement; quality policy; policies and procedures and work instructions and forms. The manager is responsible for providing oversight of the quality programme.</p> <p>D5.4 The service has policies and procedures to support service delivery. Clinical policies include a continence policy; a challenging behaviour policy; a pain management policy; a resident personal grooming and hygiene policy; a skin management policy; a wound care policy and a transport of resident's policy that includes costs and resident and staff safety.</p> <p>D10.1 The Death/tangihanga policy and procedure outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.</p> <p>Clinical guidelines are in place to assist care staff with such issues as constipation, delirium, congestive heart failure, diabetes, dementia, falls prevention, incontinence, nutrition and hydration, skin care and wound management.</p> <p>A document control and recording policy is in place. The master copy of standard operating procedures is held on the internet. Entry into the site is password protected. Hard copies of policies and procedures are held in the nursing office and administrator's office. The planned review date is determined for each policy/ procedure or form. This is usually two years from issue but may be less when documents are first issued or for documents that require an annual review. The procedure for developing new documents and reviewing and updating documents is described in the policy. The manager reports policy reviews are a collaborative effort with all the Cavell sites.</p> |

Manuals are reviewed on a rolling basis throughout the year.

The quality system is a collection of data including complaints, incidents and accidents, hazards, infections, the use of restraints and enablers, internal audits (2013 completed audits include resident satisfaction, staff documentation, care plans, kitchen, laundry, sluice, meal service, resident rooms), education and training that is provided and any other issues that are identified as opportunities for improvements. Findings are linked to the staff meetings with other meetings held as required e.g. RN meetings, kitchen meetings. The quality improvement data that is being collected (eg, falls, skin tears, infections, challenging behaviours, medication errors, infections) are collected with numbers provided to staff at staff meetings

Internal audits are completed each month as per the internal audit schedule. There is evidence to confirm the manager discusses recommendations and corrective actions in the staff meetings (minutes sighted). Audit action plans include the plan and person(s) responsible.

The manager signs off corrective actions when quality initiatives have been implemented (evidenced in three of three quality initiative corrective action forms for 2013).

Overall risks are identified, analysed and evaluated in the risk management plan. Other specific risks are addressed as part specific systems, such as health and safety, food and infection control.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management

D19.2g Falls prevention strategies are in place including hi lo beds, sensor mats, and physiotherapy assessments.

The hazard register is monitored each month by maintenance staff. Health and safety is an agenda item included in the staff meetings. Any new hazards are discussed as well as follow-up on maintenance issues.

There are two required improvements. There is a lack of evidence to reflect quality data being analysed, evaluated and used for service improvements and there is a lack of evidence of recommendations resulting from internal audits being signed off by the manager when completed.

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

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (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.

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

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

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

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| Attainment and Risk: FA |
| Evidence: |

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

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

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

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| Attainment and Risk: PA Low |
| Evidence: The quality improvement data that is being collected (eg, falls, skin tears, infections, challenging behaviours, medication errors, infections) are collected with numbers provided to staff at staff meetings. There is a lack of evidence to reflect this data being analysed, evaluated and used for service improvements. |
| Finding: The quality improvement data that is being collected (eg, falls, skin tears, infections, challenging behaviours, medication errors, infections) are collected with numbers provided to staff at staff meetings. There is a lack of evidence to reflect this data being analysed, evaluated and used for service improvements. |
| Corrective Action: Ensure quality improvement data that is being collected is analysed and evaluated with the results communicated to staff. |
| Timeframe (days): 90 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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

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

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

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

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| Attainment and Risk: PA Low |
| Evidence: The manager signs off corrective actions when quality initiatives have been implemented (evidenced in three of three corrective action forms for 2013) but there is a lack of evidence of recommendations from internal audits being signed off when completed. |
| Finding: The manager signs off corrective actions when quality initiatives have been implemented (evidenced in three of three corrective action forms for 2013) but there is a lack of evidence of recommendations from internal audits being signed off when completed. |
| Corrective Action: Ensure corrective actions resulting from internal audits are implemented and signed off when completed. |
| Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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

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

Standard 1.2.4: 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:

D19.3c The manager is aware that she will inform the Waikato District Health Board (WDHB) of any serious accidents or incidents.
D19.3c Discussions with the manager confirms that there is an awareness of the requirement to notify relevant authorities (DHB) in relation to essential notifications. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incidents and accidents. Five caregivers, two RNs and the manager report staff understand the importance of documenting incidents and accidents. Twenty completed accident/incident forms for the months of Sept and Oct 2013 were selected for review. There is evidence of an RN following up on each incident/accident with more detailed investigations where indicated. Preventative strategies are put into place where actions are indicated.

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:

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

Standard 1.2.7: 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

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| Attainment and Risk: PA Low |
| Evidence: <p>Current practicing certificates were sighted for seven RNs (including the manager), three GPs, three physiotherapists and the pharmacist. The practising certificate for the enrolled nurse has expired.</p> <p>There are comprehensive human resources policies and procedures in place. The staff employment procedure includes, recruitment, selection, orientation and appraisal. The training policy includes orientation, core training requirements, and planned training. Missing in the RNs files was evidence of medication competencies (refer 1.3.12.3).</p> <p>Four staff files (two caregivers, two RNs including the newly appointed team leader) were randomly selected for review. Staff files contained signed employment contracts, orientation documentation, reference checks, police checks, signed job descriptions and completed performance appraisals.</p> <p>The staff orientation programme provides new staff with relevant information for safe work practice and is specific to their job description (eg, caregiver, RN). All four staff files audited contain evidence of a completed orientation checklist.</p> <p>The education and training programme includes in-service education, external training, and competency testing. Discussion with staff and management confirmed that a comprehensive in-service programme is training in relevant aspects of care and support and in relation to the requirements. In-service training for 2013 includes the following: manual handling (attendance 6); chemical safety (16); code of rights (4); fire awareness (22); infection control awareness (3); personal cares (18); restraint minimisation (17); palliative care (14); CPR/first aid (6); professional boundaries (13); gastrostomy (3); clinical emergencies (19); showering competency (19).</p> <p>Registered nurses attend external training as available through the Waikato DHB. The gerontology nurse specialist visits the service when needed. Plans are in place to provide professional development for the RNs, assisting them in completing their portfolios, through the Waikato DHB beginning in March 2014.</p> <p>Four of four performance appraisals are completed in a timely manner with training needs identified.</p> |

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.

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| Attainment and Risk: PA Low |
| Evidence: <p>Current practicing certificates were sighted for seven RNs (including the manager), three GPs, three physiotherapists and the pharmacist. The practising certificate for the enrolled nurse has expired.</p> |

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| Finding: Current practicing certificates were sighted for seven RNs (including the manager), three GPs, three physiotherapists and the pharmacist. The practising certificate for the enrolled nurse has expired. |
| Corrective Action: The enrolled nurse needs to update her practising certificate. |
| Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

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

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

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| Attainment and Risk: FA |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (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.

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

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

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

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: There is staffing as per the policy around acuity and staffing ratio. There is a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty to match needs of different shifts. Family, residents and staff confirm that there is sufficient staff on duty at all times. The manager is employed full-time, Monday – Friday and is on-call 24 hours a day, seven days a week. The AM shift is staffed with one registered nurse (RN), four caregivers (two with shortened duties), and an enrolled nurse (EN) (three days a week clinical). The PM shift is staffed with one RN and three caregivers (two with shortened duties). The night shift is staffed with one RN and one caregiver. Caregivers are also responsible for laundry duties. |

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

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

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

Corrective Action:

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

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Attainment and Risk: FA

Evidence:

The previous audit noted that the resident files were not integrated. The current resident files are stored in the nurses' station in a locked cabinet. The medical notes are integrated into the current records and the archives are kept in the same office. This is an improvement from the previous audit.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Attainment and Risk: Not Audited

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

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

Attainment and Risk: Not Audited

Evidence:

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

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

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| Attainment and Risk: Not Audited |
| 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 1.3.3: 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

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| Attainment and Risk: PA Moderate |
| Evidence: <p>Assessment, planning, evaluation, review and exit are undertaken by a registered nurse with input from allied health professionals and caregivers. Service delivery is primarily undertaken by caregivers under the guidance of the registered nurses. Residents are encouraged to be as independent as possible. Assessment, care planning and evaluation are required to occur within specific time frames to safely meet the needs of the residents. The newly appointed Team Leader (who was appointed to the role two weeks ago) has re-introduced the system whereby each registered nurse has documentation responsibility for an allocated number of residents.</p> <p>The previous audit identified that documents were undated by staff. This situation continues and requires improvement. Residents are being weighed without dates being correctly recorded (See CAR).</p> <p>The previous audit identified that general practitioners (GPs) were not documenting whether residents were medically stable and able to be reviewed three monthly. GPs are reviewing residents three monthly to ensure a continuous supply of medicines. In the sample of four residents reviewed all four residents were not considered to be medically stable and the GPs were reviewing monthly or more frequently. The previous finding is considered met as no obvious shortfall was evidenced.</p> <p>Tracer Rest home resident. XXXXXX <i>This information has been deleted as it is specific to the health care of a resident.</i></p> <p>Tracer Hospital resident</p> |

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

Two other residents were reviewed (one hospital and one rest home). Both records showed a lack of timeliness in assessing and documenting care. The rest home resident admitted in August 2013 did not have an initial care plan done within 48 hours of admission and did not have a long term care plan in place on the day of audit. One resident had no weight recorded on admission. Three months later she weighed 42.65 kgs. Sometime on October 2013 she weighed 37.5 kgs. There is no active weight management plan in place (link 1.3.5.2). Care staff and the cook report that the resident eats well and they no longer mouli her food. She is not on supplementary feeding (weight loss discussed with Team Leader). Her identification photo in the medicines folder shows a loss of facial weight since the photo was taken on admission. Her initial assessment documentation was incomplete and not signed off or dated by a RN having been commenced by the enrolled nurse (link 1.3.4.2). Some initial assessments were completed by RNs.

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

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

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

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

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

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| Attainment and Risk: PA Moderate |
| Evidence: Residents are not being weighed on the day of admission and their weights are being recorded by month and year. The date the resident was weighed is not recorded and therefore it is not possible to accurately monitor weight over time. One of the four residents reviewed in the sample of records now weighs 37.5kgs (a loss of over 5kgs since January 2013. The weight was not recorded on admission in November 2012). This loss has not been recognised by care staff and the GP has made no explanatory comments on the matter in the clinical record (link 1.3.5.2). Long term care plans are not being developed, documented and evaluated by a registered nurse within three weeks of admission (D16.3). Long term care plans do not guide care or contain links to other documentation outlining a plan of care for the resident with an indwelling catheter (IDC) which is included elsewhere in his clinical record. The additional instructions are not recorded on a short term care plan (link 1.3.5.2). The previous audit identified that residents (where able) and family member (where appropriate) need to be involved in the care planning process. All four of four residents |

interviewed (three rest home and one hospital) reported they were assessed on entry to the facility and involved in the care planning process. Relatives (three hospital) confirm that their family members were assessed by staff on entry to the facility and that they were involved in the care planning process. There is documented evidence of family involvement in determining plans of care. This is an improvement from the previous audit.

The previous audit identified that general practitioners (GPs) were not documenting whether residents were medically stable and able to be reviewed three monthly. GPs are reviewing residents three monthly to ensure a continuous supply of medicines and are indicating stable where appropriate. This is an improvement from the previous audit. In the sample of four residents reviewed all four residents were not considered to be medically stable and the GPs were reviewing monthly or more frequently.

Finding:

(i) Residents are not being weighed on the day of admission. Weights are not being recorded by date (only month and year is recorded). (ii) Long term care plans are not being developed, documented and evaluated by a registered nurse within three weeks of admission (D16.3).

Corrective Action:

(i) Ensure all newly admitted residents are weighed to establish baseline information. (ii) Ensure all residents have a permanent care plan developed, documented and evaluated by a registered nurse within three weeks of admission that contains links to other documentation in the clinical file so that the care plan fully guides the provision of care.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The previous audit identified the need to ensure assessments are completed for all relevant areas for all residents. Four residents were reviewed (two rest homes and two hospital). Two of two rest home residents and one of the two hospital level residents had been admitted following the previous audit. The assessments recorded for the three residents who were admitted since the previous audit were appropriate to the residents needs with the exception of baseline weight recordings and assessments not signed and dated. This remains an improvement from the previous audit. All four of four residents interviewed (three rest home and one hospital) reported they were assessed on entry to the facility. Relatives (three hospital) confirm that their family members were assessed by staff on entry to the facility.

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

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

Attainment and Risk: PA Low

Evidence:

In four of four resident records reviewed, the assessment process was incomplete as care had not been evaluated in a timely manner to serve as the basis for service delivery planning (refer 1.3.3). One of the four residents was assessed by an enrolled nurse and the initial nursing assessment did not contain evidence of RN input.

Finding:

Initial care plans and assessments require evidence of registered nurse input and agreement in evaluating the initial care (D16.2 & D16.3c).

Corrective Action:

Ensure that each initial care plan contains evidence of registered nurse input and agreement.

Timeframe (days): 30 (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: PA Moderate

Evidence:

Three of four residents in the sample of records reviewed did not have long term care plans implemented within 3 weeks of admission (refer 1.3.3). The Team Leader confirmed she is aware of this situation and since being appointed Team Leader two weeks ago has been actively working to resolve the matter. Since appointment she has re-introduced a system of allocating residents to RNs so that the RNs can take additional responsibility for ensuring all residents documentation is accurate and

guides service provision. The recent high turnover of registered nursing staff and the recruitment and retention issues are thought to have been contributing factors.

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: PA Low

Evidence:

The previous audit found that one of three rest home resident files did not have interventions related to nutrition or weight management despite the resident having lost five kilograms since October 2011. This remains an improvement from the previous audit. One of the four residents in the current sample was also noted to have lost 5.75kgs in weight. since January 2013 when she weighed 42.65kg. She was not weighed on admission and now weighs 37.5 kgs. She is not receiving supplementary feeding. There is no reference to the weight loss in the medical records.

The previous audit found that care plans did not accurately reflect practice. This remains an improvement from the previous audit. The resident with the IDC has a care plan that does not fully reflect practice.

Finding:

(i)Service delivery plans do not describe the required support and interventions identified by the assessment process. (ii) Long term care plans do not guide care or contain links to other documentation included elsewhere in the clinical record. Additional instructions are not recorded on a short term care plan. (iii) The resident who weighed less than 40 kgs and has lost more than 5kgs since January 2013 has no plan of action or explanation recorded.

Corrective Action:

Ensure each resident has a current service delivery plan that describes all required supports and/or interventions that they need to achieve their goals or desired outcomes. Ensure residents who are losing weight or gaining weight over time are reviewed medically and are actively managed if appropriate.

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

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

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:

Service delivery is occurring (witnessed and confirmed in discussions with the manager, the team leader, one enrolled nurse, five of five caregivers, one general practitioner, four of four residents (one hospital and three rest home residents) and three relatives (three hospital residents). Care provided is documented on each shift in residents' clinical records (i.e., progress notes). Care is being discussed verbally between shifts at handovers. Appointments with external health providers are occurring and results are documented in the resident's records. There is a diary maintained of essential appointments (eg, residents who have appointments at WDHB -diary (Sighted) A GP was on site on the day of audit and was interviewed. She is happy with the standard of care provided and believes that her three other colleagues who provide services from the same medical practice hold the same view as her. Residents and relatives are satisfied with the standard of care provided and report they were welcomed and orientated to the facility and that the care provided occurs at times that reflects their expectations (confirmed in discussions with four of four residents (one hospital and three rest home residents) and three relatives (of three hospital residents).

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:

There is an activities coordinator that is responsible for activities, identifying different needs that are appropriate to their age culture and differing health status (who was on leave at the time of audit and a relieving activities coordinator was covering the programme). Normally there are two part-time activities coordinators employed who are employed on different days of the week (Monday to Friday) and who work between five to six hours a day. One works 11 am to 4.30pm, two days a week and the other works 9am to 3pm for the other three days. One a the activities coordinator works once a month on Wednesdays from 11am to 2pm so that there are two activities coordinators on staff to enable residents to have an external outing. She will also work the occasional Fridays and Saturdays from 9am to 12 midday and will come in and assist with taking residents to doctor's appointment in Hamilton which involves can involve between three to six hours per trip. The activities coordinator will escort the resident while a driver from the community drives the community hired van. The facility leases the community owned van. The van is hoist capable and can accommodate two wheelchairs. There is a combined group programme offered in the main lounge for rest home and hospital residents (the facility only has one main lounge which both rest home and hospital level residents use). There is a dining room but there is usually only one activities coordinator on duty and therefore two group programmes rarely run simultaneously. Residents who do not wish to join the group programme are able to engage in individual activities in their rooms or on fine days can relax outside on the deck. An individual activity plan for each resident is developed a few weeks after admission to the service identifying special needs, their like's dislikes and past hobbies are discussed with the resident and family/whanau where appropriate and noted on their care plans.

Activities offered in the group programme includes but is not limited to physical exercises, Tai Chi, indoor bowls walks, newspaper readings quizzes, games. There are a range of visitors to the facility which include piano players, guitar players, and singers. There is an interdenominational church service held on Tuesdays. Themed days are celebrated as are birthdays.

All four of four residents interviewed (three rest home and one hospital) reported they were involved in activities. Relatives (three hospital) confirm that their family members are including in the activities programme.

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:

Residents are required by policy to be evaluated within three weeks of admission and prior to the development of their long term care plan. Thereafter they are evaluated by their general practitioner monthly if they are not medically stable, or three monthly if they are medically stable (all four of four residents were seen by their GP within 48 hours of admission). Each resident has a six monthly evaluation meeting, which is attended by the clinical manager and the resident's GP. Family are invited to attend or to provide feedback.

One of the four residents in the sample (which was the resident with the weight loss outlined above) had been admitted to the service in November 2012. She was last reviewed in May 2013 and was due for review at the end of November. The other three of the four residents in the sample had been recently admitted and were not due for a six monthly evaluation. A further two clinical records of residents admitted prior to 2013 were reviewed to assess that residents were being evaluated formally every six months and both clinical records contained evidence of a six monthly evaluation. Staff evaluate care at the end of each 8 hour shift and write their findings in residents' progress notes.

The previous audit identified that there was no evidence of a wound being evaluated within seven days. Wound care management was reviewed. There are four residents with current wounds. Two of the four residents both have grade 1 to 2 pressure areas and the doctor and family are aware of the management plan. The other two residents have minor skin wounds (one skin tear and one blisters which is a chronic skin condition (these are known to the GP and the family of the resident with the skin tear is aware. The other resident has no family. The Team Leader has implemented a robust system for wound management. There is a visible list on a whiteboard in the nurses' station documenting all four residents who have wounds. There are wound plans and assessments documented in all four of four clinical records. This finding has been addressed. This is an improvement from the previous audit.

The previous audit identified that evaluation records for one resident did not reflect their clinical condition. No evidence of inconsistency in evaluation records was noted. This is an improvement since the previous audit.

All four of four residents interviewed (three rest home and one hospital) reported that staff discussed their care and progress with them and their families. Relatives (three hospital) confirm that their family members are assessed on an on-going basis.

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:

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

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

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

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

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

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| Attainment and Risk: Not Audited |
| 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: PA Moderate

Evidence:

The system of medicine management in use follows accepted practice and staff are familiar with the guidelines. Medicines are administered by registered nurses. Medicines are stored in a locked area when not in use. The medicine charts of 12 of the 26 residents in total were reviewed in depth. All 12 of 12 medicine charts reviewed showed that charts in use are mostly pharmacy generated with the occasional new medicines documented by a prescribing GP. Medicine order charts and administration charts are legible. All 12 of 12 medicine charts contain a dated recent photo of the resident. All 12 of 12 charts contain comments about the resident's allergy status and appropriate alerts. All 12 of 12 administration charts were signed correctly by the administering registered nurse. There was evidence of review by the residents GP in 11 of the 12 medicine charts. One chart did not contain any evidence of review within three months by a GP. The sample was extended but this was found to be an isolated case.

Errors in PRN prescribing in the medication order were consistently found in the sample. Some PRNs were well charted. The sample was extended to include a review of all medication records and the practice was found to be systemic. GPs are not consistently recording the indication for PRN medicine orders (refer 1.3.12. 1)

Controlled drugs are stored in a locked safe in a locked cupboard. There is one controlled drug register in use. A stocktake of controlled drugs occurs weekly. A stocktake was done on the day of audit and was accurate. Controlled drugs are signed for by two staff members.

The system of warfarin administration was checked and was robust.

The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards.

The process of assuring staff who administer medicines are competent is not robust (refer 1.3.12.3)

One resident of the 12 in the sample was self-administering their medicine. The system in place was robust and consistent with the guidelines for self-administration. The resident had been assessed and reassessed on 4 November 2013 as competent to continue. The medicines being self-administered are stored securely in the bedroom (storage sighted).

The previous audit identified that medicines were being administered that were not prescribed and that staff were not administering medicines according to medicine orders. No evidence was sighted of such practice occurring in review of 12 of 12 medicine charts. This is an improvement since the previous audit.

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

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

Attainment and Risk: PA Low

Evidence:

Residents are charted PRN medicines by their general practitioners. The facility is serviced by a number of GPs. A review of 12 of 12 medicine charts indicated that the charting of PRN medicines does not always reflect accepted practice, as outlined in the Medicine Care Guides for Residential aged care. The indication for the PRN is not always stated.

Finding:

The indication for PRN medicine orders is not always documented by the prescriber.

Corrective Action:

Ensure the prescriber of PRN medicines clearly indicates the rationale for the use of the PRN medicine.

Timeframe (days): 60 (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: PA Low

Evidence:

The manager (who is a registered nurse) has no evidence that she has been assessed as competent to administer medicines or assess other staff as competent. She reported that she was formally assessed several years ago. Registered nurses administer medicines in the facility. They have yet to be formally assessed as competent to administer medicines. The administration of medicines by a registered on the day of audit was observed and the correct administration procedure was followed. No evidence was sighted of harm to residents occurring and the likelihood of harm occurring is assessed as low

Finding:

All registered nurses who administer medicines have yet to be formally assessed as competent.

Corrective Action:

Ensure all staff who administer medicines demonstrate competency to a registered nurse who has demonstrated competency and that the assessment process and outcome is documented.

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

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

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

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

Criterion 1.3.12.6 (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.

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

Standard 1.3.13: 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

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| Attainment and Risk: PA Low |
| Evidence: There is a small functional kitchen which adjoins the sole dining room. The majority of food is cooked on site. Three cooks are employed over a number of split shifts (two of which were interviewed). Cooking occurs from 6.45 am to 1.30 pm and recommences at 3pm to 6pm. The cooks are assisted by kitchen hands. There is a food services manual to guide practice. All residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is |

reviewed six monthly as part of the care plan review. There is an external provider dietician available for individual resident need and for menu development. The four weekly rotating menu is varied. The menu was last reviewed by a dietitian on 6 September 201. Meals and snacks are served at times that reflect community norms. Outside of regular meal times staff can and will provide a nutritious snack or drink if residents are hungry or thirsty (confirmed in discussions with five of five caregivers). The two cooks interviewed reports that they are able to cater for dietary requirements. No residents at the time of audit were on supplementary feeding. One resident has a continuous PEG feed which is totally managed by the registered nurses. Residents have access to specialist feeding utensils eg, feeding cups and special cutlery, lipped plates, and non-slip mats are available for residents that require these items.

The nutrition management and food control plan covers all aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal and complies with current legislation and guidelines. It includes a section on food safety management that covers (but is not limited to); Hazard Analysis Critical Control Point; responsibilities; cook's meeting; staff training; personal hygiene; environment; food hygiene procedures; and recording, monitoring, corrective action and auditing.

The main grocery shop is done by the owners of the facility and the cook (interviewed) reported that it occurs weekly according to the menu. Food temps are taken of cooked food prior to serving. Refrigeration and freezer temperatures are monitored and are maintained in the correct ranges. Food is stored in the pantry, the fridge and the freezer. Food sighted in the fridge and freezer was stored appropriately. However food in the pantry and in the kitchen was not stored correctly (refer 1.3.13.5). Food waste is collected every three days by an external person. There is a comprehensive cleaning schedule in place. Unlabelled chemicals were found in use in the kitchen (refer 1.3.13.5). Maintenance is required to a kitchen cupboard (refer 1.3.13.5)

The previous audit identified that one cook had not received training in safe food handling. This has been corrected and is an improvement since the previous audit. D 19.2 The cooks have been trained in safe food handling.

Four of four residents interviewed (one from the hospital and three from the rest home) said their likes and dislikes are catered for and they are satisfied with the food service. . Relatives (three hospital) confirm that their family members enjoy the food served.

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

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

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

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

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

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| Attainment and Risk: FA |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (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.

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| Attainment and Risk: PA Low |
| Evidence: Flour is being stored in the kitchen in a container without a lid exposing the product to the risks of contamination. Skim milk powder supplies are being stored in two large unlabelled containers. There is one unlabelled bottle of chemical in use in the kitchen (refer Criterion 1.4.2). No evidence of harm to residents through these practices was found. There is a cupboard under the sink where the cupboard doors require maintenance (Kitchen staff report the cupboard is not used). |
| Finding: Food storage practices for dried food are not consistent with safe food storage guidelines and all chemicals in use are not labelled. |
| Corrective Action: Ensure food is stored appropriately according to safe food practice and that chemicals are stored in labelled containers. |
| Timeframe (days): 30 (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 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: Not Audited

Evidence:

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The building has a current warrant of fitness which expires 27 April 2014. Chemicals in use are not stored correctly and two hoists are overdue for servicing (refer 1.4.2.4).

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Chemicals in use in the facility (resident areas, toilets and showers and the kitchen) are being decanted into unlabelled containers. The manager reports that the service is in the process of changing chemical suppliers. Interviews with the new cleaners report that new cleaning products that are labelled will be used. Two hoists have not been serviced since October 2011 and are overdue for servicing. There is no evidence of harm occurring to residents however risk exists.

Finding:

Chemicals are in use and are not being stored safely in correctly labelled containers. Two hoists in use have not been serviced since October 2011.

Corrective Action:

Ensure all chemicals are stored safely in correctly labelled containers. Ensure hoists used to lift residents are serviced annually to minimise the risk of harm to residents.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: PA Low

Evidence:

A number of issues required attention at the previous audit. The radiator in the dirty laundry with peeling paint and some rust evident has since been painted, which is an improvement. The rusty radiator in Toilet two has been painted. Room 24 bedside table/trolley that had peeling paint has been removed from use. Sluice room two had peeling paint on cupboard doors and the window sill. The cupboards have been removed and the window sill has been painted. These are all improvements from the previous audit. Additional improvements were identified (refer 1.4.3.1).

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

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

Attainment and Risk: PA Low

Evidence:

The previous audit identified that the swing bar with the chipped paint and rust in Toilet 2 required painting. This defect has not been addressed. This remains an improvement from the previous audit. In addition there are a number of other surfaces throughout the toilets and shower areas that continue to require attention, which are as follows:

1. There is a broken wall surface in the right hand side toilet next to the sluice room opposite Room 4.
2. There is broken linoleum in the visitors' toilets
3. There is a broken wall surface in the toilet/shower opposite the staff room
4. There is a rusted chain attached to a tap in the toilet opposite Room 21 and holes in the wall surface in this toilet

All these surfaces are unable to be easily cleaned in line with infection prevention guidelines and may present a risk of harm to residents.

The manager advised that toilet 2 was addressed post the previous audit, this 'swing bar is old and is on the list for replacing. They are currently going through renovations and changes to areas that get constant use i.e toilets and showers. These areas are on the list of replacement, however the priority for the new addition and renovations to the rest home wing have been the priority.

Finding:

There are broken surfaces in toilets and shower areas that do not meet the needs of consumers, as the surfaces are not able to be easily cleaned.

Corrective Action:

Ensure maintenance issues are addressed and that all surfaces can be easily cleaned in line with infection prevention guidelines and minimise the risk of harm to residents.

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

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: Not Audited

Evidence:

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.) |

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |

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

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

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

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

Attainment and Risk: Not Audited

Evidence:

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

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

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: Not Audited

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

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| Attainment and Risk: FA |
| Evidence: <p>The policy includes a definition of enablers and restraint. The service identifies enablers as equipment, devices or furniture, voluntarily used by a resident following appropriate assessment which limits the normal freedom of movement of a client with the intention of promoting independence, comfort and/or safety. The process of assessment and evaluation of enabler use is documented. The policy states that the resident will be fully informed regarding the purpose and use of the enabler and will voluntarily agree to its use.</p> <p>At the time of the audit, three hospital level residents were using bedrails as a restraint and no residents were using enablers.</p> |

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.

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

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

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

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| Attainment and Risk: Not Audited |
| Evidence: |

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

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

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

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

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

Attainment and Risk: Not Audited

Evidence:

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: Not Audited

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 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 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: Not Audited

Evidence:

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: Not Audited

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 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

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

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

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| Attainment and Risk: Not Audited |
| Evidence: |

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

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

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| Attainment and Risk: Not Audited |
| Evidence: |

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

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| Attainment and Risk: Not Audited |
| Evidence: |
| Finding: |
| Corrective Action: |
| Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i> |

Standard 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.

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| Attainment and Risk: FA |
| Evidence: Surveillance for infection occurs as part of the infection prevention and control programme and is described in the Raglan Hospital & Rest Home infection control policy and in the risk management plan which is developed annually (last reviewed 23 January 2013). Monthly infection data are collected on all infections by the RNs and given |

to the manager who is the IPC coordinator. The data are monitored and evaluated. Outcomes and actions are discussed at the registered nurse and enrolled nurse meetings and other staff meetings (minutes sighted). Benchmarking occurs within the service from month to month and externally with other Cavell Group providers.

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.

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

Criterion 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.

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