# TerraNova Homes & Care Limited - Monte Vista Residential Care

## Current Status: 19 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

Monte Vista Residential Care is an aged care service owned and operated by the TerraNova Home and Care Group. The service provides rest home and hospital level of care.   
  
The two areas of required improvement that were identified at the previous certification audit are now addressed and areas of improvement have been implemented since the last audit. There are no new areas of required improvement identified at this unannounced surveillance audit.

## Audit Summary as at 19 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 |
|  | 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 19 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. |  | Standards applicable to this service fully attained. |

### Organisational Management as at 19 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. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 19 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. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 19 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. |  | Standards applicable to this service fully attained. |

### Restraint Minimisation and Safe Practice as at 19 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. |

### Infection Prevention and Control as at 19 November 2013

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

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## **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**

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| --- | --- |
| **Legal entity name:** | TerraNova Homes & Care Ltd – Monte Vista Residential Care |
| **Certificate name:** | Monte Vista Residential Care |

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| **Designated Auditing Agency:** | DAA Group Ltd |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance | | | |
| **Premises audited:** | 1-23 Shepherds Road, TAUPO | | | |
| **Services audited:** | Rest home and hospital level of care | | | |
| **Dates of audit:** | **Start date:** | 19 November 2013 | **End date:** | 19 November 2013 |

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| **Proposed changes to current services (if any):** |
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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 26 |

## **Audit Team**

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

## **Sample Totals**

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

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 8 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 4 | Number of staff records reviewed | 4 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 8 | Total number of staff (headcount) | 35 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the 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:

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| --- | --- | --- |
| 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 | No |
| g) | the DAA has provided all the information that is relevant to the audit | Yes |
| h) | the DAA has finished editing the document. | Yes |

Dated Monday, 9 December 2013

## **Executive Summary of Audit**

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| **General Overview** |
| Monte Vista Residential Care is an aged care service owned and operated by the TerraNova Home and Care group. The service provides rest home and hospital level of care.  The two areas of required improvement that were identified at the previous certification audit are now addressed and areas of improvement implemented since the last audit. There are no new areas of required improvement identified at this unannounced surveillance audit. |

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| **Outcome 1.1: Consumer Rights** |
| Communication is managed in an effective manner. There is evidence of open disclosure with family, ensuring they are kept informed of any change in the resident’s condition and/or any adverse event. A complaints process is in place, meeting requirements set by the Health and Disability Commissioner’s Office. A complaints register is in place. Staff, families and residents understand the complaints process. |

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| **Outcome 1.2: Organisational Management** |
| Services are planned, coordinated, and are appropriate to the needs of the residents. Day-to-day operations are being managed efficiently and effectively. This ensures the provision of timely, appropriate and safe services to the residents. Quality and risk management processes are documented and maintained, reflecting the principals of continuous quality improvement. Adverse, unplanned and untoward events are recorded in a systematic fashion and are reported to those affected in an open manner.  Residents receive appropriate services from suitably qualified staff. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. Adequate numbers of staff are available to meet the needs of the residents. This includes a minimum of one registered nurse who is onsite seven days a week, twenty-four hours a day. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The registered nurse conducts the initial assessment and initial care plan on the resident’s admission to the service. The service implements the TerraNova process for assessment and care planning. The provision of care is based on the assessed needs of the resident. The assessment, care planning, review and evaluation processes are conducted within time frames that meet the residents’ needs. The previous area of required improvement to ensure the evaluation of care documents the resident’s progress towards meeting goals and desired outcomes is now addressed and an area of improvement implemented since the last certification audit.  The planned activities are based on the TerraNova organisational wide Life Enhancement programme. The activities are planned to meet the needs and strengths of the residents.  The menu is reviewed six monthly by a dietitian to ensure it is suitable for older people living in a care facility. The residents report high satisfaction with the options offered.  A safe medicine management system is observed on the day of audit. Staff who are responsible for medicine management are assessed as competent to perform the role. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| There have been no building alterations since the last audit. A current Building Warrant of Fitness is posted in a visible location. One shower room that was identified as requiring refurbishment has been completed. This is an improvement since the last audit. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are clear guidelines in the restraint policy to determine what is a restraint and what is an enabler. The restraint standards are being implemented. Implementation is reviewed and evaluated through internal audits, facility meetings, and regional restraint meetings. At the time of audit, the service has three residents on the restraint register using an enabler and three residents using a restraint. |

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| **Outcome 3: Infection Prevention and Control** |
| The service has implemented the TerraNova requirements for the collection and analysis of infections. The service has an appropriate system for the surveillance of infections, that reflects the size and scope of the service. The infection surveillance data is benchmarked with the other TerraNova facilities, as well as externally with other aged care organisations. Where the infection rates are higher than expected the service implements a risk management plan to address any shortfalls identified. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 17 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 0 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 62 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
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## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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

#### Standard 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An open disclosure policy is in place. This includes a definition for open disclosure, key principles of open disclosure, who should be involved, and key steps for open disclosure.   Three relative interviews (one relative with a family member in the rest home and two relatives with a family member in the hospital) confirm they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of communication with family is evidenced in the progress notes for all four clinical records selected for review and in all eight of the health and safety (accident and incident) forms selected for review. |

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A complaints policy is in place. The policy defines timeframes for responding to a complaint, meeting the Health and Disability Commissioner’s requirements. The branch manager reports there has been one complaint investigated by the Health and Disability Commissioner (HDC) since their last audit.  Complaints forms are readily available at the entrance to the facility. Interviews with three caregivers, the clinical coordinator and one registered nurse (RN) confirm their understanding of the complaints process. Interviews with four residents (three rest home level and one hospital level) and three families (two with a relative in the rest home and one with a relative in the hospital) understand the process for lodging a complaint. Resident meetings are held monthly and provide a means for residents to voice concerns and suggestions. Residents and families interviewed report the branch manager is approachable and open to suggestions.  The branch manager holds the complaints register in her office. There have been four written complaints lodged in 2013 with evidence of follow-up actions that meet the Health and Disability Commissioner’s (HDC) required timeframes. All documentation relating to lodged complaints are held in the complaints register.  One complaint was lodged with the HDC on 9 April 2013. The complaint was acknowledged on 10 April 2013. A complaints investigation was undertaken with responses provided to the HDC by the branch manager on 25 April 2013 and 2 August 2013. It was determined by HDC on 9 September 2013 that no further action was required. A recommendation was made by HDC to ensure GP reviews are consistent with best practice.   Complaints are tracked monthly by the head office and are benchmarked against other TerraNova sites. |

##### **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.

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| TerraNova Homes and Care Ltd. owns and operates five aged care facilities in Auckland, Hawke’s Bay, Lower Hutt and Taupo. A vision, and mission statement are defined for the organisation. The Monte Vista Residential Care facility, located in Taupo, is certified to provide rest home and hospital-level care for up to 41 residents. On the day of the audit, there were 16 rest home-level residents and 10 hospital-level residents living at the facility.  The branch manager is a registered nurse who has been employed by TerraNova since March 2012. She holds a current annual practising certificate and postgraduate diplomas in management and public health. She has experience in health management consulting in aged care and has worked as an operations manager for the Oceania Group. She also has an auditing qualification. She attends quarterly TerraNova managers' meetings and Lakes District Health Board Providers meetings. She also regularly attends external professional development courses. Professional development relating to the management of an aged care facility exceeds eight hours per year.  A clinical coordinator, who is a registered nurse, supports the branch manager. The clinical coordinator, one staff RN, and three caregiver staff report the branch manager has the appropriate amount of experience to manage the facility efficiently and effectively. They report she is approachable and listens to their concerns. |

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A quality/business plan 2012 – 2013 is in place for Monte Vista Residential Care. Seven objectives are listed in the plan including: 1: to work each month within the budget; 2) to sustain or exceed budged occupancy; 3) conversion of rest home to hospital rooms; 4) ensure the roster procedures are adhered to and the safe levels of staffing are maintained; 5) food services; 6) life enhancement programme; and 7) clinical and team nursing. Each objective includes an anticipated outcome, prerequisites and co-requisites, actions and indicators. The quality and risk management system is understood and being implemented by the branch manager and clinical coordinator.   Policies and procedures are aligned with current good practice and service delivery. All policies and procedures are stored electronically and in hard copy at the facility (sighted). Policies are linked to applicable legislation and evidence-based practice guidelines. Each policy includes a review date and related documents. Policies are reviewed two-yearly unless changes occur more frequently. Branch managers from all TerraNova sites are involved in the review of policies. A TerraNova Accreditation Pack (TAP) provides the branch manager with monthly policy updates. Standard operating procedures and guidance notes are in place for approval and publishing of policy and procedures. The document control system ensures policies and procedures are approved, up-to-date, readily available to staff and are managed to avoid the use of obsolete documents.  Key components of service delivery are linked to the quality system. The internal audit programme involves comprehensive monitoring of service delivery. The monitoring of essential services (eg, event reporting, complaints management, infection prevention and control, health and safety, and restraint minimisation) is included in the annual internal audit programme. Results are documented on a ‘balanced scorecard’ with evidence of markers where thresholds exceed acceptable limits.  There are 17 other criteria being audited, including but not limited to, clinical records. Quality improvement data are collected, analysed and evaluated. The branch manager is responsible for ensuring all internal audits are completed according to the audit schedule. Each internal audit includes audit objectives, method, frequency, associated documents and a scoring process. Results of the internal audits are communicated to staff in the monthly meetings (evidenced in the staff meeting minutes).   Corrective actions are put into place where identified and are used to guide improvements. Six completed internal audits were selected for review (food services (August 2013), restraint use (August 2013), environmental safety (September 2013), and discharge/transfer process (September 2013). Action plans are documented where opportunities for improvements are identified. There is evidence of sign-off by the branch manager or clinical coordinator when the corrective actions have been completed. One example for 2013 included an increased rate of medication errors (peak in April 2013). The corrective action was regarding medication administration competencies. In addition, a corrective action relating to medication management has been combining regular and non-regular medications onto one form. A second example of a corrective action was the identification of staff who still needed to complete their restraint minimisation competency questionnaire following an internal audit of the restraint programme.  There are two examples of quality initiatives provided by the manager relating to the cleanliness of the environment and residents’ food choices. The branch manager reports that she was unhappy with the cleanliness of the facility. She increased the frequency of the environmental audits to monthly and has now gradually reduced the frequency based on results of the positive findings. During the tour of the facility, it is noted that the facility is clean with fresh scents. Interviews with three caregivers verify that the facility is kept clean and tidy.   Monte Vista was selected as the trial facility to provide residents with food choices for their midday meal. Key persons were selected to be involved in this project (chef, administrator, clinical coordinator, activities coordinator and the branch manager). Menus were selected and evaluated. It was important not to duplicate food choices in the two menus, yet also provide nutritional benefits in both menus. Menu selections were taken from previously approved menus. Seasonal vegetables are included in both menus. The trial was so popular it was extended for another four weeks and has now been implemented as a permanent feature of the facility.   Risks are identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from reoccurring and/ or how to deal with the risk in the event of its re-occurrence. Hazards are identified on the hazard register. The register is updated as new hazards are identified. Risks and hazards are monitored through the internal audit programme (sighted). |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The branch manager understands statutory and regulatory obligations. Examples include notification to the appropriate authorities (eg, Occupational Safety and Health, Lakes District Health Board, Ministry of Health) in regards to serious injuries, coroner's inquests, changes in management and complaints lodged with the Health and Disability Commissioner.  Adverse events (eg, falls, skin tears, medicine errors, and drug reactions) are recorded and trended on a health and safety form. Data collected includes evidence of open disclosure (reference 1.1.9), risk rating, actions taken and sign off by the branch manager of the actions taken. A registered nurse is responsible for the investigations. Eight health and safety forms were selected for review. All eight forms were completed in a comprehensive manner.  Data is collected and collated monthly. Once data is collected, the results are benchmarked against other TerraNova facilities with evidence of analysis of the data. Results are communicated to staff at the monthly staff meeting and are posted in the staff room. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Annual practising certificates, which include scope of practice, are validated with copies of certificates held in each health professional's personnel file. All registered nurses (seven), physiotherapist, podiatrist, pharmacist, and GP (14) annual practising certificates are current.  The appointment of service providers to safely meet the needs of the residents includes mandatory police checks and reference checks prior to staff commencing employment.   A comprehensive TerraNova staff induction handbook is in place. Completed induction checklists were sighted in all four staff files audited (three caregivers and one RN). This includes (but is not limited to) the employment agreement, position description, quality management and care, residents' rights, evacuation plan, confidentiality, risk assessments, the Code of Rights, Health and Safety, lifting and moving of residents, first aid, unsafe handling practices, infection control, hand washing, medications, missing residents, abuse and neglect, employment agreement, cultural awareness, emergency procedures, complaints, incidents, hazards, security and intruders. Further induction programmes are in place specific to the role of the employee (eg, caregiver, RN, clinical coordinator). Three of three caregivers report that the induction programme is comprehensive.  A system has been put into place to identify, plan, facilitate and record ongoing education for staff. Two-yearly mandatory training is in place. Education attended in 2013 includes cultural awareness; restraint minimisation; pain management; health and safety; six-monthly fire training; use of hoists; care plan documentation; correct use of mobility aids; wound care; dealing with colostomy, caregiver competency reviews, falls prevention and management; and, chemical safety. Two yearly mandatory education also includes open disclosure, informed consent, sexuality and intimacy, first aid/CPR, managing challenging behaviours, consumer code of rights, complaints and advocacy, communication, stress, abuse and neglect, enduring power of attorney, privacy, hazard management, accident and incident reporting and investigation, spirituality, medication administration, continence management, feeding swallowing and hydration, pain management, death, wound management, infection control, Liverpool Care Pathway and syringe driver, skin care and integrity.   Aged Care Education (ACE) modules 1-4 is completed for all caregivers within their first six months of employment (evidenced in two caregivers’ files selected for review). |

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a documented process in place for determining staffing levels. Rosters are completed electronically using Time Target, which matches staffing levels to occupied beds. Registered nursing cover is provided seven days a week, 24 hours a day.   One registered nurse works the 7am-3pm shift (in addition to the clinical coordinator (two days a week) and the branch manager (Monday – Friday). One registered nurse works the 3pm - 11pm shift and one registered nurse works the night shift. A part time RN and a casual RN are available for relief cover. Agency staffing is available but has not been used since December 2012.   Caregiver staffing at the current occupancy reflects two caregivers on the full morning shift and one on a shortened shift (7:30am – 1:00pm), one caregiver on the 3pm – 11pm shift and one caregiver on a shortened shift (4pm – 9pm) and one caregiver on the night shift.   The branch manager reports staff may be asked to work a ‘double shift’ in special circumstances. Interviews with four residents and three relatives confirm staff are available to meet their needs. |

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

## **Outcome 1.3: Continuum of Service Delivery**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The TerraNova organisation’s processes are implemented and imbedded at the service to ensure the residents receive timely, competent and appropriate services in order for their assessed needs and desired outcomes. Interviews with four of four residents (three rest home and one hospital) and three of three families/whanau report high satisfaction with the provision of care and services at Monte Vista.   Each stage of service provision is undertaken by suitably qualified and experienced staff. The registered nurses (RN) have annual practising certificates. There are competency assessment for the care and nursing staff to ensure the staff are competent to perform their roles. Caregivers are offered ongoing education to ensure they have the skills to perform their role. There are five senior caregivers with expanded roles and competencies. All caregivers have completed the first four Aged Care Education (ACE) modules within the first six months of employment. All staff who require an APC have these verified annually.  The initial assessment and initial care plan is developed on the first day of admission. The long term care plan is developed within three weeks of admission. The care plans are reviewed and evaluated at least six monthly. The medical reviews are conducted three monthly, when the resident is assessed as stable, this exception for the three monthly review is recorded in the resident’s file (confirmed in the four of four residents’ files reviewed). The care plans are based on the assessed needs of the residents. The service utilises the standardised format for assessment and care planning, with these individualised to each resident (confirm in the four of four residents’ files reviewed). The care plan covers the physical, social, spiritual and cultural needs of the resident. The care plan format includes the issue, goal and the required intervention. Where the resident has additional or specialised needs the service implements care pathways (eg, pain, falls, weight management, palliative care).   There is a verbal handover each shift. The three of three caregivers report that they receive adequate information at the verbal handover. The service has a system through ‘Time Target’ electronic log on to pass messages to the staff as they sign in at the start of the shift. The progress notes are updated at least once a shift by the caregivers and RNs.  Tracer example 1 – hospital level of care:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer example 2 – rest home level of care  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  The relevant ARRC requirements for rest home and hospital level of care are met. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The four of four residents’ files reviewed (two rest home and two hospital) evidence the provision of services and interventions are consistent with meeting the residents’ assessed needs. Where the resident has an assessed need, this is identified on the care plan, with goals set and interventions developed (with resident and family input) to meet the desired outcomes. The care plan is a standardised care plan that covers the needs of the resident. When more specialised interventions are required, the service uses care pathways. If the resident has a care pathway, this is identified on the long term care plan. The hospital level of care resident reviewed has a care pathway for falls management. The three of three caregivers interviewed report that the care plan gives adequate information on how to provide care for each of the residents.   The four of four residents and three of three families/whanau interviewed report satisfaction with the provision of care and services.   The relevant ARRC requirements for rest home and hospital level of care are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The activities programme is based on the TerraNova life enhancement programme. The two activities co-ordinators interviewed report that the programme is directed by the resident where possible, with the monthly resident meeting providing an opportunity for residents to have input into the upcoming events. The activities programme also incorporates TerraNova’s organisational wide 'wishing tree' programme for residents who have something meaningful that they would like to achieve, as well as the men focused ‘Blokes Shed’ and the women focused ‘Ribbons and Lace’ clubs.   The activities programme includes activities that are physical, intellectual, sensory, social and reminiscing. Weekly group activities are designed to reflect the interests of the resident that includes; group activities, one to one pampering, competitions, outings and music and visiting entertainment. Group activities, such as, indoor bowls were observed on the day of audit. The service has a number of clubs. The activities assessments sighted in four of four residents' files include the resident’s interests and what is meaningful to the resident. The four of four residents' files sampled demonstrate diversional therapy and recreational plans, demonstrate support is provided within the areas of leisure/recreation, health and well-being, and evidence completed activities assessment tools.  The four of four residents interviewed reported their interests and preferences are met in the activity programme. The residents did comment that the service could benefit from a van or bus to enable more of the residents to go on outing. The activities coordinators reports that the service does have two cars to take residents out into the community and that they have access to a van from a local charitable organisation. The two activities co-ordinators interviewed indicate that the planned activities can change based on the interest in the activity and has alternatives to the planned programme if the resident's ability or interest is not matched to the planned activity.    Families/whānau are welcome to contribute and participate in the recreational activities. The service also has a day activities programme where members of the community come to the service for the day.   The relevant ARRC requirements for rest home and hospital level of care are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Previous CAR at 1.3.8.2 to ensure evaluations are consistently completed to indicate the degree of response to the supports and/or interventions, and progress towards meeting desired outcomes is now addressed and an improvement implemented since the last audit.  The evaluations sighted in the four of four residents’ files are individualised to the resident and identify if the goals are met. If the goals are not met the care plan is updated to reflect the resident’s changed needs. The long term care plan is evaluated at least six monthly (confirmed in the four of four residents’ files reviewed). If the resident has a specific care pathway, these are reviewed at least monthly. The hospital level of care resident reviewed has a care pathway for falls management, which is reviewed and evaluated at least monthly.  When progress is different from expected the service uses short term care plans for acute issues. Short term care plans are sighted for infections, falls and skin tears. If the issue is ongoing, this is documented in the long term care plan.   The four of four residents and three of three families/whanau report satisfaction with the care and services provided.   The relevant ARRC requirements for rest home and hospital level of care are met. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The majority of the medicines are dispensed from the pharmacy in the robotic sachet delivery system. These are delivered by the pharmacy monthly. The RN interviewed reports that the sachets are checked for accuracy against the medicine chart on delivery and at each administration of the medicines (observed at time of audit). A safe medicine administration process is observed at the time of audit (RN and student nurse observed administering the lunch time medicines).   The medicine charts are computer generated by the pharmacy, with the GP signing each medicine ordered, as evidenced on the eight of eight medicine charts reviewed. The eight of eight medicine charts reviewed have a prescription that meets legislative and safe practice guidelines. The eight of eight medicine charts reviewed record any medicine related allergies or sensitivities. The three monthly review of the medicines is recorded on the medicine chart, as confirmed on all eight medicine charts reviewed.   The medicines are stored in a locked room. The medicine trolley is stored in the locked room when not in use. There is a weekly stock rotation and checking of expiry dates for medicines that are not delivered in the robotic sachets. The medicine fridge is checked daily for temperature, the sighted recordings are within the required safe medicine storage guidelines. The controlled drugs are stored in a locked medicine safe in the medication storage room. The controlled drugs are signed out by two staff at each administration with a weekly stock count recorded in red pen in the controlled drug register. The pharmacy conducts a six monthly stock check of the controlled drugs and medicine audit, this is last conducted in August 2013   The RNs are responsible for medicine management, with all RNs having an annual competency for medicine management. All the medicine and insulin administration competencies sighted for the RNs are current (sighted).   At the time of audit there are no residents who self-administer their medicines. The service has a competency assessment form to assess if residents are competent to self-administer their medicines.   The relevant ARRC requirements for rest home and hospital level of care are met. |

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

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

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

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

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

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

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

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

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

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

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

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

#### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management **(**HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The menu used at the service is the organisational wide menu developed for the TerraNova group by an external food service. The four week menu with seasonal variations is reviewed six monthly by a registered dietitian, with the summer menu review last conducted October 2013. The dietitian report identifies that the menu is well balanced and aligns with nutritional guidelines for the older person. Residents are routinely weighted monthly, and when the need is indicated, the weights can be more frequent to reflect the resident’s changed needs. A copy of the nutritional requirements for each of the residents is provided to the kitchen staff. There is a white board that highlights individual resident’s preferences and special or modified diets. The chef interviewed states that resident requests are accommodated where possible. The chef reports there is one resident with very specific nutritional requests and each morning the resident meets with the cook to plan what modifications are required to meet the residents individual needs. The four of four residents interviewed provided excellent feedback about the meals provided at Monte Vista.   All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. Any decanted food is dated and labelled. Staff have undertaken food safety management education appropriate to service delivery.  The relevant ARRC requirements for rest home and hospital level of care are met. |

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There have been no building modifications since the last audit. A current Building Warrant of Fitness is posted in a visible location (expiry 11 May 2014). One shower room that was identified for refurbishment has been completed. This is an improvement since the last audit. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous CAR at 1.4.3.4 identified that one of the showers required repair to enable easy cleaning to comply with infection prevention and control guidelines. One shower room that was identified for refurbishment has been completed. This is now addressed and an area of improvement implemented since the last audit. |

# 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:** |
| The process of assessment and evaluation of enabler use is the same as a restraint and included in the restraint minimisation and safe practice policies. Currently the service has three residents on the register with an enabler in the form of a bedrails or bed wedges. There are also three residents using a restraint.  The file reviewed of one resident using an enabler included a comprehensive assessment that covered alternatives and least restrictive options. The resident and a family member signed an enabler consent form. The use of the enabler is linked to the resident’s care plan. |

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Surveillance frequency and type is set out in policy and determined by the TerraNova infection control expert committee. It is appropriate for the size and complexity of the facility. Infection control data is collected on urinary tract infections (UTIs), skin infections, bronchitis, colds, conjunctivitis and influenza like illness. The monthly report of collected data is provided at staff meetings. Infection control data is included in annual quality audits and management programmes. The infection control data is benchmarked with other TerraNova services through the clinical indictors and balance score card system and external benchmarking with other aged care services.  The quarterly benchmarking results indicate the rest home and hospital services are below the average for the total number infections per 1000 occupied bed days. The infection control officer (RN/clinical coordinator) reports that there was an increase in UTIs in September 2013. The September 2013 surveillance records four UTIs with nil recorded in August 2013. The individual residents have infection control action plans, which include encouragement of fluids, informal education related to personal hygiene and antibiotic usage where this is indicated. The infection control coordinator reports that the increase in UTIs is reflective of seasonal changes and increased staff education on standard precautions, encouragement of fluids and environmental cleaning has occurred as part the risk management plan. |

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

##### **Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

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