

# Ruapehu Masonic Association Trust

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Current Status: 16 January 2014

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

## General overview

Masonic Court rest home provides rest home level care for up to 53 residents. On the day of audit there was 42 residents. The service continues to implement a quality and risk management programme. The manager is an enrolled nurse with 27 years management experience in aged care. She is supported by a full time registered nurse with considerable aged care experience.

Four of four shortfalls from previous audit have been addressed. These are around registered nurse assessment following accident/incidents, employment reference checks, integration of resident files and weight loss management.

This audit identified further improvements required around interventions for behavioural management, observations post incident/accident, linking restraint risks to care plans and GP prescribing of 'as required' medications.

## Audit Summary as at 16 January 2014

Standards have been assessed and summarised below:

### Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

### Consumer Rights as at 16 January 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 16 January 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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### Continuum of Service Delivery as at 16 January 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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### Safe and Appropriate Environment as at 16 January 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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### Restraint Minimisation and Safe Practice as at 16 January 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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## Infection Prevention and Control as at 16 January 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## 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

<b>Legal entity name:</b>	Ruapehu Masonic Association Trust		
<b>Certificate name:</b>	Ruapehu Masonic Association Trust		
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited		
<b>Types of audit:</b>	Surveillance Audit		
<b>Premises audited:</b>	Masonic Court Rest Home		
<b>Services audited:</b>	Rest home care (excluding dementia care)		
<b>Dates of audit:</b>	<b>Start date:</b> 16 January 2014	<b>End date:</b> 17 January 2014	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			41

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	4
<b>Other Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	1

## Sample Totals

Total audit hours on site	12	Total audit hours off site	5	Total audit hours	17
Number of residents interviewed	4	Number of staff interviewed	7	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	45	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	0

## Declaration

I, XXXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Thursday, 13 February 2014

## Executive Summary of Audit

### General Overview

Masonic Court rest home provides rest home level care for up to 53 residents. On the day of audit there was 41 residents including one resident on respite care. The service continues to implement a quality and risk management programme. The manager is an enrolled nurse with 27 years management experience in aged care. She is supported by a full time registered nurse with considerable aged care experience.

Four of four shortfalls from previous audit have been addressed. These are around registered nurse assessment following accident/incidents, employment reference checks, integration of resident files and weight loss management.

This audit identified further improvements required around interventions for behavioural management, observations post incident/accident, linking restraint risks to care plans and GP prescribing of 'as required' medications.

### Outcome 1.1: Consumer Rights

There is an open disclosure policy, which describes ways that information is provided to residents and families/representatives at entry to the service. Family are involved care planning and receive and provide on-going feedback. The privacy and dignity of residents is respected. Residents meetings are held and resident/relative surveys are completed annually. Four residents and four relatives interviewed confirmed they are contacted if an incident/ accident or a change in resident's health status occurs. There is a complaints register that is maintained. The service has documented verbal concerns and there is evidence of follow up and resolution.

### Outcome 1.2: Organisational Management

There is a quality and risk management programme and process that has been established and implemented. There is an internal audit schedule, which is completed. Quality data is collated monthly, trends identified and corrective action plans implemented.

There is discussion of quality data and any identified improvements evidenced at staff meetings including management, staff, health and safety/infection control meetings. There is an implemented planned annual in-service programme for all staff that includes monthly training. Staff training records are maintained. Annual performance appraisals are completed. Staff and residents reported that staffing levels are sufficient.

### Outcome 1.3: Continuum of Service Delivery

Care plans and evaluations are completed by the registered nurse. Risk assessment tools and monitoring forms are available. There is an improvement required around interventions for the management challenging behaviour, neurological observations and inclusion of restraint risks into care plans. Care plans demonstrate service integration. Short term care plans are used for acute changes in health status. There has been an improvement around weight loss management since the previous audit. The resident/relative/whanau are involved in the evaluations of care plans six monthly. The diversional therapist provides an activities programme for the residents that is varied, interesting and involves the families and community. The activity care plans are individualised. This is an improvement from the previous audit.

Storage, delivery and administration of medications meet medicine management requirements. Staff administering medication has completed medication



## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	<p>i) There are no neurological observations following a fall with knock to the head.</p> <p>ii) Risks identified with the use of a restraint has not been documented in the long term care plan</p> <p>iii) There has been no behavioural assessment/behaviour monitoring for a resident with altered behaviour. There is no plan for the use of alternative strategies prior to the administration of prn medication.</p>	<p>i) Ensure neurological observations are in place post falls with head injury.</p> <p>ii) Ensure risks identified with the use of restraint is documented on the long term care plan.</p> <p>iii) Ensure behavioural assessments are completed for altered behaviours identifying triggers and alternative strategies for de-escalation.</p>	90
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 Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	Four of 10 medication charts viewed did not have the indications prescribed for the use of prn medications (tramadol, loperamide, GTN, morphine elixir and diazaepam).	Ensure all prn medications have an indication for use prescribed on the medication chart.	90
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 Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	The chair scales require calibration and the two hoists require functional checks.	Ensure clinical equipment is calibrated and checked.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Full information is provided at entry to residents and family/representatives. Ethnicity and language is identified on admission and interpreter services are accessed as required. Families are involved in the initial care planning and in on-going care. A family contact form in the resident files evidence contact and discussion with family members regarding resident change in health status, incidents/accidents and other relevant matters.

ARC D11.3 The information pack is available in large print and advised that this can be read to residents.

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. This includes 'charging in ORAs - no other benefit for services'.

D16.4b: Interviews with four relatives confirmed that they are always informed when their family members health status changes and for any accidents/incidents that occur.

A sample of incidents forms (ten) reviewed identified that all ten forms evidenced that family were contacted.

The manager and registered nurse are readily available to residents and families and promote open communication.

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

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

**Attainment and Risk:** FA

**Evidence:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. The manager is responsible for ensuring complaints are addressed within the required timeframe and maintains contact with the complainant throughout the complaints process. The registered nurse (RN) is involved in any complaints regarding care. A concerns and complaints register is maintained. There are two verbal concerns and one email (for 2013) that have been processed in the same way as written complaints. The documentation for each concern shows investigation and actions taken for resolution to the satisfaction of the relative.  Staff attended education on concerns and complaints October 2013.  Complaints, outcomes and improvements are discussed at monthly staff meetings, three monthly health and safety and infection control meetings. The manager provides a monthly report including concerns and complaints to the home committee. Interviews with four relatives confirmed that they were well informed around the complaint</p>

process. Four residents interviewed stated they are aware of the concern/complaints process and feel comfortable approaching management should they have any concerns. The manager and RN are readily available and have an “open door” policy.  
D13.3h. A complaints procedure is provided to residents within the information pack at entry.

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

**Attainment and Risk:** FA

**Evidence:**

The Ruapehu Masonic Association Trust have overall financial responsibility for the complex. The home committee is made up of 13 designated representative of the each lodge. The chairman and secretary attend both meetings. The manager attends the monthly home committee meeting and provides an operational and clinical report.

A board member (interviewed) advised the 2014-2015 business and quality plan would be signed off by the board at the February meeting. The 2013-2014 business and quality management plan sighted included a purpose and goals to achieve a quality service and maintain a high occupancy.

The plan is separated into sections and focus areas, including a) financial goals, b) property, c) risk management, d) clinical goals, e) staff training, f) internal auditing programme, g) resident/relative satisfaction and a business analysis of strength, weakness, opportunity and threats (SWOT).

Masonic Court rest home provides rest home level care for up to 53 residents. The manager has been in the role for the Masonic Court rest home for 27 years. The manager is an enrolled nurse (EN) with a current practicing certificate and has attended at least eight hours of management education. D17.3di (rest home) The manager attends education offered through New Zealand Aged Care Association and nurses forum at the Whanganui DHB. A RN is employed full time and on-call. The RN has been with the service for one year and has worked in aged care for the last 15 years. The RN has completed an advanced diploma of nursing and degree in 2003 (nursing bridging programme). A current annual practicing certificate is sighted. The RN has completed InterRAI training. A casual RN is employed to provide cover in the RN absence/leave. The manager and RN have access to a regional Aged care education/consultant.

Policies and procedures are developed at an organisational level with input from staff and external specialist expertise where required.

#### Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Masonic Court Rest Home has an established quality and risk management system. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of continuous quality improvement. Quality and risk performance is reported across the facility meetings and a set agenda item for the three monthly health and safety and infection control meetings, restraints meeting and monthly full staff meetings (includes all services). The monthly managers' report to the home committee covers staffing, occupancy, audits (internal and external), complaints and compliments, survey results and significant clinical events. Policies and procedures are developed at organisational level and reflect current good practice adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The policies and procedures are reviewed regularly in consultation with the relevant person or committee. The policy manuals are readily accessible to all staff. The review or release of new policy are discussed at the staff monthly. Education sessions follow the monthly meeting. Staff interviewed are knowledgeable in quality improvement systems and state they are involved in ideas and suggestions for improvement. There is an opportunities for improvement form available for staff use. Six staff interviewed (across services and variety of shifts) confirmed they are aware of the results of internal audits, health and safety and infection control data, trends and corrective actions, new or reviewed policies and procedures

Key components of the quality and risk management system link to the organisational meetings at every level. Residents care issues, clinical updates, audit results and corrective action plans, improvement projects, complaints/compliments, policies and reviews, staff training, infection control and health and safety are set agenda items at the RN, manager and staff meetings held monthly. The infection control committee comprises of the manager and RN (joint infection control co-ordinator) and representatives from the caregivers, kitchen and housekeeping services. Monthly infection control data is collated, trends and corrective actions discussed at all meetings. The infection control co-ordinators provide a monthly report to the Home Committee. There are monthly accident/incident data and reports completed and made available to staff. Outcomes and corrective actions are discussed at staff meetings. The health and safety committee is attended by the manager, board representative, resident advocate, caregiver, housekeeping and maintenance person (board representative).

Frequency of monitoring is determined by the internal audit schedule. Audit results forms and action plans are signed off as completed where a noncompliance is identified. Staff have input into the annual review of internal and external environmental hazards. Notices are placed in each area for staff feedback. An example is an identified hazard of burns from the kitchen steamer when preparing porridge for breakfast. The kitchen hazard control plan has been reviewed to include the wearing of appropriate protective wear for the prevention of steam burns. The reviewed hazard control plan has been discussed at the staff meeting and health and safety meetings (meeting minutes sighted).

Results from the resident satisfaction survey completed in July 2013 and food satisfaction survey completed June 2013 were discussed at the organisational meetings and collated results forwarded to the Home Committee.

D19.3: There is a comprehensive health and safety and risk management programme in place. The manager is the health and safety co-ordinator.

The risk management plan is due to be reviewed at the home committee meeting and the 2014-2015 risk management plan developed. There is a current hazard register.

D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Strategies and equipment are available to minimise falls risk.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**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:**

There is an accident and incident policy. Incidents, accidents are investigated and analysis of incidents trends occurs. There is a discussion of incidents/accidents at the staff meetings and health and safety meetings. The manager forwards a monthly health and safety report and annual analysis of incidents/accidents to the home committee meeting including actions to minimise recurrence.

Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Collation of data, trends and corrective actions are made available to staff. Six staff interviewed are aware of the outcomes of incidents/accidents and internal audits.

Ten resident accident/ incident reports from the period September to November 2013 were reviewed. The incident/accident form documents date, name of resident, place, time, type of incident/accident, any injury, contributing factors and if a resident, staff or visitor, corrective actions and next of kin notified. The RN follows up incidents/accidents ensuring corrective actions are implemented and linked to the care plans. The RN signs all incident/accident forms within a timely manner. This is an improvement since the previous audit. Ten incidents are traced back to the care plans and progress notes of respective residents. All 10 care plans and progress notes reflected the incident and corrective/preventative strategies implemented. The manager on interview is able to describe the provider's responsibility in regards to essential notifications to the correct authority.

One incident of resident fall with minor head injury did not have neurological observations (link 1.3.6.1).

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.

### **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:**

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The recruitment and staff selection process requires that relevant checks, including police checks are completed to validate the individual’s application, qualifications and experience. A copy of current annual practising certificates are sighted for the enrolled nurse/manager, full-time registered nurse and casual registered nurse. Five staff files were reviewed (full-time registered nurse, one recently employed cook/kitchen hand, one laundry worker and two caregivers). Reference checks are completed before employment is offered. This is an improvement from the previous audit.</p> <p>The orientation programme provides new staff with environmental safety, infection control and relevant information for safe work practice. Two recently employed staff confirm that they are supported in the work place. Signed job descriptions and contracts are on the personnel files sampled. The RN appraisal is scheduled to occur with regional RN aged care consultant/educator.</p> <p>There a draft in-service plan in progress for 2014. The registered nurse and manager attend training including seminars and sessions provided by the local DHB and external trainers. Education provided in the last two years (2012/2013) includes: cultural awareness, challenging behaviour, code of rights, open disclosure, elder protection, security and emergency preparedness, informed consent, manual handling/falls prevention, medication (annually), chemical safety, pressure injury prevention,</p>

restraint minimisation, privacy and dignity and infection control. Continence management is scheduled for February 2014 with the product representative. Individual staff training records are maintained. In-service is scheduled monthly to follow the staff meetings. Fourteen of the 20 caregivers employed hold the national certificate in the support of the older person.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication, insulin administration and use of oxygen. The RN attends mandatory eight hour study days at the DHB that covers RN/EN specific education and competencies. The RN's and manager hold a current first aid certificate.

#### **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.

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

#### **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.

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

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

**Attainment and Risk:** FA

**Evidence:**

Sufficient staff are on duty per shift to manage the care requirements of the rest home residents. The manager and registered nurse both work 40 hours per week Monday-Friday and are available on call. Interviews with four caregivers, four residents and four family identify that staffing is adequate to meet the needs of residents. There is a policy for determining staffing levels and skill mixes for safe service delivery. Caregivers interviewed confirmed there are adequate staff numbers on duty to safely deliver residents cares. Resident acuity is monitored and additional staff are available to assist with more dependant residents such as palliative care residents. The caregiver's state there is good after hour's clinical and emergency support for the staff.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D.16.2, 3, 4: The five resident files sampled (rest home) identified that the RN complete an initial assessment within 24 hours. The RN has countersigned assessments and care plans developed by the EN/manager. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. All five files sampled identified that the long term care plan is developed within three weeks. All five long term care plans sampled are signed/countersigned and dated by the RN. There is documented evidence of resident/family/whanau involvement in the development and review of the care plans. Allied health professionals involved in the residents care are linked to the support care plan review such as, dietitian, physiotherapist and podiatrist. Allied health notes are maintained in the residents file. All five resident files sampled documented discussions with family/whanau on the contact with family form regarding changes to health, incidents, infections, MDT meetings, and GP visits.

D16.5e: Four of five resident files sampled identified that the GP had seen the resident within two working days. One resident had been seen by the physician prior to discharge from hospital. There is a main GP for the service however; residents may retain their own GP. The GP is unavailable for interview on the day of audit. It was noted in all resident files sampled that the GP had examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status. An after hour/on call GP service is provided during week days and through the GP clinic at the Whanganui DHB on public holidays and weekends. The RN assesses and initiates ambulance transfers to emergency department for more urgent concerns. The RN interviewed refers residents to nursing specialists such as continence, wound, speech language therapist, dietitian, physiotherapist, and community mental health team as required and notifies the GP. The GP send referrals for consultants and medical specialists including the geriatrician and psychogeriatrician. All five resident files sampled identified integration of allied health professionals and a team approach.

There is a verbal handover at the beginning of each shift to the caregivers to ensure staff are kept informed of resident's health status and any significant events. The communication books and progress notes are read. Four caregivers interviewed state the communication system is very good and they relevant information at handover to deliver safe and timely cares for the residents.

Tracer methodology: rest home resident

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The physiotherapist documents referral outcomes in the allied health progress notes of the resident integrated file. A copy of recommended exercises is kept in the integrated file. The DT (interviewed) supervises and assists the resident with daily exercises as per physiotherapist instructions and retains a copy of the exercise plan in the DT folder. This is an improvement from the previous audit.

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

Service delivery plans demonstrate service integration.

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

## 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:** PA Low

### Evidence:

The service provides services for residents requiring rest home level care. Individualised care plans are completed. When a resident's condition alters, the registered nurses initiates a GP review and if required a referral to specialist nursing services. The GP initiates referrals to medical consultants or specialists.

D18.3 Dressing supplies are available and adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment is sighted. There are adequate supplies of incontinent products in all areas.

Wound assessment and wound care treatment form is in place for one chronic wound and one pressure area of sacrum. The chronic wound and pressure area is linked to the resident's long term care plan. Short term care plans are in place for two skin tears.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day and night use. On-going strategies for coping with incontinence are documented in the residents file. Specialist continence advice is available as needed and the RN could describe the referral process.

All falls are reported on the resident accident/incident form. The GP is notified of falls with injury and residents with frequent falls. A referral is sent for physiotherapy assessment if required. Neurological observations are required following falls with head injury. Falls risk assessments are completed on admission and reviewed at least six monthly or earlier if required.

Resident's weight is recorded on admission and monitored monthly. Chair scales are available. A nutritional screening is completed for residents identified with weight loss. Interventions required such as increased weighing frequency, high calorie diet, supplements, GP or dietitian referral are included in the care plan. This is an improvement from the previous audit.

Restraint use for one rest home resident and associated documents are viewed. The restraint use is linked to the long term care plan. Restraint assessment and reviews are completed. The risks identified with the use of the restraint are not documented in the long term care plan. This is an area requiring improvement.

Changes in behaviour are reported in the progress notes and followed up by the RN. The GP is notified and medical cause such as UTI is excluded. Medications are reviewed. There is an improvement required around interventions for challenging behaviour. One resident who had a fall and sustained a knock to the head did not have neurological observations completed. This is a further area requiring improvement.

### 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:** PA Low

### Evidence:

When a resident's condition alters, the registered nurses initiate a review and if required GP consultation.

- i) All falls are reported on an incident/accident form.
- ii) Restraint assessments are completed for residents prior to the use of restraint. Risks associated with the use of restraint are identified on the risk assessment form.
- iii) One resident with altered behaviour and hallucinations has been seen by the GP for management of symptoms.

**Finding:**

- i) There are no neurological observations following a fall with knock to the head.
- ii) Risks identified with the use of a restraint has not been documented in the long term care plan
- iii) There has been no behavioural assessment/behaviour monitoring for a resident with altered behaviour. There is no plan for the use of alternative strategies prior to the administration of prn medication.

**Corrective Action:**

- i) Ensure neurological observations are in place post falls with head injury.
- ii) Ensure risks identified with the use of restraint is documented on the long term care plan.
- iii) Ensure behavioural assessments are completed for altered behaviours identifying triggers and alternative strategies for de-escalation.

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

**Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)**

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

**Attainment and Risk:** FA**Evidence:**

The service employs a qualified registered diversional therapist (DT) 38-40 hours a week to implement the activity programme for the rest home residents. The DT is involved with the Whanganui DT support group and attends education and training days as available. The DT holds a current first aid certificate. An activity assistant (DT in training) works one day a week. There are volunteers who assist with resident activities and outings. There is an annual recreation plan for 2014 with set days for entertainers, regular outings, community visitors, church services, men's fellowship, and special events such as mother's day, father's day, St Patricks day and Melbourne cup. Other group activities are planned into the weekly calendar. All residents receive a copy of the activity plan. One on one time is spent with residents who do not wish to participate in group activities. Residents are encouraged to maintain their community links and attend RSA, church groups, embroidery group, blind foundation meetings and St Johns club as identified in the individual activity care plan. A mobility taxi van is hired for outings to attend inter-home visits, concerts, picnics, Whanganui museum, and opportunity concerts. Resident meetings are held monthly and a guest speaker attends two monthly. Residents have the opportunity to feedback on activity programme through the meetings and individual surveys. The DT completes a social history on admission with the new resident/family/whanau. A recreational therapy plan is developed within three weeks of admission. The review of the care plan is six monthly and co-ordinated with the RN clinical care plan reviews. The DT maintains fortnightly progress notes in the resident's integrated file. The DT is a representative on the health and safety/restraints meeting.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There is documented evidence of multidisciplinary reviews held six monthly involving the resident/family/whanau, RN, caregivers, recreational/DT officer. The RN amends the long term support plan to reflect on-going changes as part of the review process. The short term care and support plans are evaluated regularly and resolved or added onto the long term care plan as an on-going problem. The GP completes a three monthly resident review and medication review.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

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

**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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>There is one main locked medication/treatment/GP room. The medication trolley is locked. There are adequate stocks of pharmaceutical supplies. The supplying pharmacy delivers supplies and the monthly blister packs. The pharmacist is available after hours as necessary. The RN checks all medications on delivery and completes a medication reconciliation. Pharmacy fax orders and a pharmacy delivery book is maintained. The RN and medication supervisors (senior caregivers) complete annual medication competencies. Annual education is provided through the community pharmacist at the DHB. An aged care consultant within the region is available as a clinical advisor/mentor and completes the RN medication competency. There are weekly controlled drug checks sighted in the controlled drug register. Two medication competent staff sign for the administration of controlled drugs. The RN and EN/manager complete a six monthly stocktake of all medications. There is one resident who self-medicates night time medication. This is kept safe in a locked drawer and the resident notifies the staff when it has been taken. The resident, GP and RN have signed the self-medication assessment. There are weekly fridge temperature recordings within the acceptable range. All eye drops are dated on opening. Medication signing sheets are all correct with no gaps. All prn medications are timed on administration. The caregivers contact the RN for authorisation to administer a prn medication. Ten medication charts sampled had photo identification and allergies noted on the medication chart. All prescribed medications on the 10 medication charts are signed by the GP. There is an improvement required around the prescribing of prn medications.</p>

D 6.5.e.i.2; 10 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly.

**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:**

All prescribed medications on the 10 medication charts are signed by the GP. The prescribing of regular medications meets legislative requirements. Six of 10 medication charts have indications for use for prn medications.

**Finding:**

Four of 10 medication charts viewed did not have the indications prescribed for the use of prn medications (tramadol, loperamide, GTN, morphine elixir and diazaepam).

**Corrective Action:**

Ensure all prn medications have an indication for use prescribed on the medication chart.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

**Attainment and Risk:** FA

**Evidence:**

There is a qualified cook on duty daily from 6am to 2pm. The cook is supported by two kitchen hands (one on dining room duties and one on kitchen duties). The caregivers prepare breakfast and deliver to the resident rooms. There is a four weekly summer menu in place that has been reviewed by the dietitian. The cook receives a resident dietary profile on admission. Resident likes/dislikes and special dietary requirements are known. There are alternative choices offered. Special diets include gluten free, low potassium and pureed meals. There are special plates (lip plates/plates for the visually impaired) to promote resident independence at meal times. The cook is notified of any residents with weight loss and meals with extra calories are provided and food charts maintained. Fridge and freezer temperatures are monitored weekly. Hot food temperature recording is completed daily on the midday meal. The kitchen is well equipped with a good work flow. Equipment has been tested and tagged. All dry goods are sealed and dated in the pantry and off the floor. All foods in the fridge is dated. Staff are observed wearing correct protective clothing. Chemicals are stored safely. Staff have attended food safety hygiene and chemical safety (August 2013).

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

**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.

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Masonic Court rest home has a current building warrant of fitness, which expires on 22 June 2014. The board member (interviewed) completes the monthly planned

maintenance schedules. Checklists signed included call bells, water temperatures and environmental checks. The board member has completed training for electrical testing. Equipment is tested and tagged for electrical warrant of fitness. The chair scales and two hoists require a functional check. This is an area requiring improvement. All furniture is purchased to meet the needs of the consumer group. The upgrade of 12 rooms with ensuite toilets is complete and there is a plan to refurbish the remaining existing rooms. Residents were observed to be able to mobilise freely around the communal areas of the facility with or without mobility aids. There is safe access to external areas. The gardens and grounds are well maintained. Caregivers interviewed confirm they have adequate equipment to safely deliver cares for residents including; standing and sling hoist, chair scales, wheelchairs, walking frames and other mobility aids, electric beds, shower chairs, pressure area mattresses, roho cushions, lifting belts, transfer board and turntable.

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

All buildings, plant, and equipment comply with legislation.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Caregivers interviewed confirm they have adequate equipment to safely deliver cares for residents.
<b>Finding:</b> The chair scales require calibration and the two hoists require functional checks.
<b>Corrective Action:</b> Ensure clinical equipment is calibrated and checked.
<b>Timeframe (days):</b> 90 (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

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### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy identifies that restraint is used as a last resort. The process of assessment and evaluation of enabler use is included in the policy. There are currently no residents using enablers. The service has three residents assessed as requiring bedrails. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The use of restraint is linked to the care plan for the three residents with an enabler. The use of restraint is reviewed every six months and there is two hourly monitoring in place when the restraint is in use. The

restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings.

#### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The infection control policy includes a surveillance policy. The surveillance policy includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infections included in the monthly surveillance data are; lower respiratory tract, skin and soft tissue, urinary tract infection, eye infection, diarrhoeal, multi resistant organisms and other suspected infections.

A monthly surveillance report is completed by the infection control officer/RN, which is distributed to all staff and presented at the Infection Control Committee at the three monthly meeting. The infection control surveillance data identifies any trends, corrective actions and quality improvements. Surveillance data is discussed at the monthly staff meeting and education provided as relevant. The manager reports any significant infection control issues to the board in a timely manner. There have been no

outbreaks.

**Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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