# Real Living (Services) Limited

## Current Status: 7 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

Kensington House provides rest home level care for up to 32 residents. At the time of the audit, there are 32 residents. The service is managed by an experienced aged care nurse manager who has been in the role since 2001. The manager is supported by a registered nurse on afternoon shifts seven days a week.

Improvements are required to the following: communication to family members, integrated resident records, care planning, documentation of medications, and food services.

## Audit Summary as at 7 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 |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

### Consumer Rights as at 7 January 2014

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

### Organisational Management as at 7 January 2014

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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 7 January 2014

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

### Safe and Appropriate Environment as at 7 January 2014

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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 7 January 2014

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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 7 January 2014

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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 4.0)

## **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:** | Real Living (Services) Limited |
| **Certificate name:** | Real Living (Services) Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Kensington House | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 7 January 2014 | **End date:** | 8 January 2014 |

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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:** | 32 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXX | **Hours on site** | 10 | **Hours off site** | 6 |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 1 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 10 | Total audit hours off site | 7 | Total audit hours | 17 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 6 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 4 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 29 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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| --- | --- | --- |
| 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 Monday, 24 February 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Kensington House provides rest home level care for up to 32 residents. At the time of the audit, there are 32 residents. The service is managed by an experienced aged care nurse manager who has been in the role since 2001. The manager is supported by a registered nurse on afternoon shifts seven days a week. Improvements are required to the following: communication to family members, integrated resident records, care planning, documentation of mediations, and food services. |

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| **Outcome 1.1: Consumer Rights** |
| Kensington House provides care and support that focuses on the individual with residents, the general practitioner and relatives praising the services provided. Family state that they are informed of any incidents. Complaints processes are implemented and complaints and concerns are actively managed and documented with a complaints register completed by the manager. The service encourages the documentation of verbal complaints as a tool to improve quality of service delivery.  An improvement is required to documentation that family members have been informed following an incident. |

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| **Outcome 1.2: Organisational Management** |
| Kensington House provides rest home level care and there is a quality and risk management programme implemented with management and use of quality data to improve service delivery. This includes review of incidents, accidents, hazards; infections; complaints; and resident/family satisfaction surveys. An internal audit schedule is implemented.  There is a roster implemented as per policy with staff, the general practitioner, residents and family confirming that there are sufficient staff on duty to provide residents with required support. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Assessments, care plans and evaluations are completed by the nurse manager and registered nurses. Residents/relatives are involved in planning and evaluating care. Residents and relatives interviewed comment positively on the care delivered at the service.  An initial assessment and plan is completed within 24 hours of admission to the service and there is a reassessment and review of the care plan six monthly. There is an improvement required around integration of resident records, interventions and updating of care plans in response to changes. An activities programme is provided on weekdays in the afternoon with residents and family confirming that it is varied and interesting.  Staff responsible for the administration of medication are competency assessed annually. There is an improvement required around medication management. All meals are prepared on site on the kitchen in the village and these on the day of the audit are nutritious and well presented. Individual and special dietary needs are catered for. Residents interviewed are complimentary about the meals provided. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The rest home building holds a current warrant of fitness and there is a planned maintenance programme in place. All equipment is calibrated. There is sufficient space to allow the residents to freely move around the facility using the mobility aids and residents describe the environment as being warm, ‘family orientated’ with outdoor areas to sit in. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has a restraint free philosophy and there are no restraints or enablers used. All staff have had training around restraint, enablers and management of challenging behaviours. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection control policies and procedures are documented. There is a designated registered nurse identified as the infection control coordinator with the nurse manager providing oversight of the programme. Infection surveillance is conducted to identify trends and results of analysis of data used to improve service delivery. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 10 | 0 | 3 | 3 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 6 | 2 | 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 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | The incident forms do not routinely record that family have been informed after an incident. | Ensure that incident forms record evidence of family being notified after an incident. | 180 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.4 | The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | There is a lack of integrated records and documentation of issues and interventions in a variety of places e.g. progress notes, problem page and care plan. | Ensure that each resident has an integrated folder with information kept in the logical sequence and place. | 180 |
| 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 Moderate |  |  |  |
| 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 Moderate | Interventions and strategies to manage issues are not well documented in the long term or on short term care plans. | Document detailed interventions for all issues in the care plan or in short term care plans. | 90 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.8.3 | Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | The care plan or a short term care plan is not completed or updated to reflect the issue due to the changes, interventions and evidence of ongoing review. | Update the care plan and/or document a short term care plan when changes occur for a resident. | 60 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | (i)Three eye drops currently in use are not dated. (ii) Three drugs are expired and one has a cracked base but is still on the shelf. | (i)Date all topical medications that have explicit expiry dates from when opened. (ii) Ensure that all medication is in safe containers and that these have not expired. | 60 |
| HDS(C)S.2008 | Criterion 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. | PA Low | Registered nurses transcribe instructions around medications on the resident medical data form. | Cease the practice of transcribing of instructions for administration of medication. | 30 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.2 | Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Low | Kitchen staff do not have a copy of allergies and food preferences in the kitchen. | Provide kitchen staff with a copy of allergies and food preferences to be documented in the kitchen. | 30 |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | (i)While there is evidence of checking of hot food temperatures, this has lapsed during the leave period of the cook. (ii) Monitoring of fridge/freezer temperatures is not taken in the kitchen. | (ii)Check hot food temperatures consistently. Ii) Monitor fridge/freezer temperatures to ensure that they are in the correct range. | 90 |

## **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:** PA Low |
| **Evidence:** |
| There is a policy around open disclosure. There is an interpreter policy which includes references to resources.  Contact with family members is confirmed through interview of four family members.  At times, evidence of contact with the family following an incident is recorded on the accident/incident form (documented in five of the 15 incident forms reviewed).  Two caregivers interviewed, the registered nurse and nurse manager (registered nurse) interviewed confirm that family are informed of any resident accidents or incidents. There are no residents currently requiring interpreting services. D16.4b Four of four family members confirm that there is good communication with the service with the nurse manager providing an open door policy. Four of four residents interviewed confirm that they are communicated with well.  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.  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 are not covered by the agreement. D11.3 The information pack is available in large print and advised that this can be read to residents. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| 15 incident forms reviewed confirm that family have been notified on five of the forms. |
| **Finding:** |
| The incident forms do not routinely record that family have been informed after an incident. |
| **Corrective Action:** |
| Ensure that incident forms record evidence of family being notified after an incident. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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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:** |
| There is 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. A complaints register is maintained with complaints documented for 2013 and the register and folder shows investigation of all complaints, dates and actions taken for resolution.  A complaint from a family member was tracked for monitoring purposes and the review identifies that the complaint is resolved in a timely manner with communication to the family documented.  D13.3h. A complaints procedure is provided to residents within the information pack at entry. Four of four family members and four of four residents interviewed confirm that they know how to make a complaint and all state that there is no reason for them to make a complaint but feel that any concerns would be resolved if they were raised. All state that the service is ‘excellent’, ‘a special place’, ‘family atmosphere’.  The nurse manager states that there have not been any complaints lodged with the Health and Disability Commission, District Health Board or Ministry of Health. |

##### **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:** |
| Kensington House is part of a group of facilities that includes two rest homes. The service provides care for up to 32 rest home residents. On the day of the audit, there are 32 residents including one resident from the village requiring respite. The shareholders and thereby the owners are experienced providers of aged care having been involved in the industry for over 18 years. The overall vision is ‘quality care at affordable rates’. The welcome to Kensington House includes the vision, history and description of the services provided.  The staff meeting minutes reflect discussion of the philosophy of care.  Kensington House has appropriate management systems, policies, procedures, codes of practice and guidelines purchased from an independent consultant which are implemented and maintained at the rest home.  The service is managed by an experienced nurse manager who has been in the role since 2001 and has worked in the facility for several years before that. She is supported by three other registered nurses, an enrolled nurse and caregivers who provide support 24 hours a day, seven days a week.  ARC,D17.3di (rest home): The nurse manager has maintained at least eight hours annually of professional development activities related to managing a rest home. |

##### **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:** |
| The nurse manager provides leadership for and oversight of the quality programme with the administrator completing tasks such as implementation of the internal audit schedule. D5.4 The staff meeting minutes reflect discussion of the philosophy of care. Kensington House has appropriate management systems, policies purchased from an external consultant, procedures, codes of practice and guidelines which are implemented and maintained. The policies are reviewed annually and there is a document control process that includes documentation of the latest review and when the policy is next for review.  There is an annual quality plan and the 2013 plan is currently being reviewed with a new plan documented by the nurse manager for 2014. Quality initiatives for 2014 described by the nurse manager include renovation of the lounge following a report around earthquake safety and refurbishment of rooms for residents.  Discussions with the nurse manager, registered nurse, two caregivers and review of meeting minutes demonstrates staff involvement in quality and risk activities.  The staff meeting is the key tool used to communicate quality improvement initiatives and data. These are held six weekly with resident/family meetings held twice a year. All aspects of the quality and risk management programme are discussed. The service has a non restraint policy and there is an annual meeting (last held in November 2013) to document overview of the programme.  Annual resident and relative surveys are undertaken with the last collated in October 2013 with a high level of satisfaction. The service responds to any areas of dissatisfaction individually with residents if they are identified and looks for ways to improve the service through overview of all comments. There is also a six weekly post admission survey used to establish if residents and family are happy with the service.  D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety is addressed through the staff meetings as well as through informal discussion as described by staff and the nurse manager interviewed. A hazard register is documented and hazard identification forms identify that any hazards are addressed in a timely manner and discussed at meetings. There is a maintenance book with evidence that any issues are addressed in a timely manner.  D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.  D19.2g Falls prevention strategies such as staff supervision, no restraint used and a review of any incidents around falls are implemented. There is an implemented internal audit programme and all audits identify corrective actions required and these are documented with sign off of resolution in a timely manner. Discussion of audits and any corrective actions occurs through the staff meetings. |

##### **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:** |
| 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. The service identifies that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the MoH. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.  Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required.  Meeting minutes from the staff meetings reflect discussions of incidents/accidents and actions taken.  A review of incident/accident forms for Kensington House (15 reviewed) identifies that all 15 incident forms are fully completed and include follow-up actions taken. |

##### **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:** |
| A register of registered nurse, enrolled nurse, doctor, podiatrist, dietitian, pharmacist practising certificates are kept within the facility indicating that all relevant staff and other health professionals have a current APC.  There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.  Four staff files reviewed (one registered nurse, two caregivers, one enrolled nurse) include relevant induction books, referee checks, training, and development records. Kensington House has an orientation/induction programme that provides new staff with relevant information for safe work practice. Two caregivers interviewed describe the buddying role for new caregivers.  There is a training programme in place that offers monthly workshops for staff. Attendance records reviewed indicate that these are well attended and cover aspects of care and service delivery related to the rest home level of care.  There is an implemented education plan (sighted for 2013). The annual training programme well exceeds eight hours annually.  Annual formal performance reviews are in place for reflective practice and setting goals including up skilling or other training or qualification and all four files reviewed include a current performance appraisal. D17.7d: There are implemented competencies for staff relating to medication. The sample of files was increased by three to confirm that staff do have medication competencies including administration of insulin on file. Registered nurses are supported to maintain their professional competency.  Four of four staff files include a job description, contract, a record of a completed orientation, application and training records.  The nurse manager confirms that all staff except for the activities coordinators have a staff file. The activities coordinators are contacted into the service. |

##### **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 roster of staff and it is noted on the day of the audit that the staffing level matches that plan on the roster.  The actual staffing level is determined according to need both within the rest home also with provision to provide some level of cover if required for the large retirement village complex next to the rest home.  For the 32 residents there is a registered nurse on duty each afternoon and the nurse manager is on duty with hands on clinical care for three mornings a week and completes office work for the other two days a week. The nurse manager is on call 24 hours/seven days a week with designated registered nurses if required.  Staff turnover is also noted to be low.  The following staff are rostered:  AM: two caregivers 7am-1pm and one caregiver from 7am-3pm.  PM: one caregiver 4.30pm-8pm, one caregiver 3pm-11pm, one registered nurse 3pm-11pm.  Night: one senior and one other caregiver on from 11pm-7am.  Two caregivers who work morning shift and the registered nurse who works PM shifts state that there are sufficient staff to complete tasks and provide support for residents. |

##### **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:** PA Low |
| **Evidence:** |
| There is a policy and process that describe resident’s admission and assessment procedures. A registered nurse undertakes an initial assessment and care plan on admission, with the initial support plan completed within 24 hours of admission.  D16.2, 3, 4: A nursing assessment is completed on entry and reviewed six monthly – sighted in five of five files as being current and reviewed.  Other assessment tools are completed in resident files on admission and six monthly if required e.g. falls risk assessment, continence assessment, pain assessment. Activity assessments and the activities care plans have been completed by the activities coordinator. The consent form is signed on the day of entry and includes consent for health information to be released, use of photos, consent to be transported, consent to cares and choices, information to be given to family, consent to be checked by nursing staff at night. Advance directives are documented in the four files reviewed and signed only by the resident with the doctor deeming competence. Care plans are documented by the registered nurses and reviewed six monthly.  Currently there are a number of folders that include the resident notes i.e. the file with the consent forms, advance directives, admission data and older progress notes; one folder with all resident care plans, progress notes and any problem pages; a weight folder, a dressing folder; activity notes kept by the activities staff, medication folder kept in with the medication. The care plan and progress note folder is used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs.  The GP interviewed spoke very positively about the service and describes effective communication processes.  Methodology:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  An improvement is required to integration of records and information. |

##### **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:** PA Low |
| **Evidence:** |
| Resident information is kept in a variety of folders with issues and interventions documented in a variety of places. |
| **Finding:** |
| There is a lack of integrated records and documentation of issues and interventions in a variety of places e.g. progress notes, problem page and care plan. |
| **Corrective Action:** |
| Ensure that each resident has an integrated folder with information kept in the logical sequence and place. |
| **Timeframe (days):** 180 *(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:** PA Moderate |
| **Evidence:** |
| The service provides services for residents requiring rest home level care. Care plans are completed with some interventions documented as issues are identified.  Five resident care files were reviewed for this audit.  The service uses a problem page to document new issues or changes in state.  The care being provided as described by the registered nurse, nurse manager and the two caregivers interviewed is consistent with the needs of residents. The GP interviewed states the facility applied changes of care advice immediately and was complimentary about the quality of service delivery provided. Residents' needs are assessed on admission. Interventions and strategies to manage issues are not well documented in the long term or on short term care plans and this is identified as an area requiring improvement. D18.3 and 4 Dressing supplies are available and a nurse’s room is stocked for use. Continence products are available and these are individualised. Specialist continence advice is available as needed and this could be described. Continence management in-services (February and August 2013), pain management (October 2013), nutrition and food handling (November 2013) and wound management in-services (February 2013) have been provided. |

##### **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:** PA Moderate |
| **Evidence:** |
| Some interventions are included in the care plan, on the evaluation form, progress notes and some on the problem page.  a) For one resident for example, there is no documentation in the care plan of management of long term XXXX although the progress notes, the evaluation of the care plan in November 2013 and the problem page identify this as an ongoing issue.  b) One resident is identified as having XXXX are not well documented. The doctors note states that the resident should be referred to the services for older adults however there is no mention of this in the care plan or in other notes.  c) One resident has XXXX in the problem page. The notes do not detail sufficiently the dressings required, size, shape, exudate, progress for each with some documentation of progress in the progress notes and some in the dressing folder. |
| **Finding:** |
| Interventions and strategies to manage issues are not well documented in the long term or on short term care plans. |
| **Corrective Action:** |
| Document detailed interventions for all issues in the care plan or in short term care plans. |
| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The activities coordinators (two) have long involvement with the rest home/provision of activities and provide activities for three hours in the afternoon five days a week with extra time once a week to take residents out on outings.  All recreation/activities assessments and reviews are up to date.  On the day of audit, residents were observed being actively involved with a variety of activities in the lounge.  Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Activities include art and music therapy, exercise, bowling, games, bus trips and movies. One to one activities are provided to residents. The four residents and four family members interviewed stated that activities are appropriate and varied enough for the residents.  D16.5d: Five of five resident files reviewed identified that the individual activity plan is reviewed when at care plan review.  While a weekly/monthly plan is not documented, all residents interviewed know to come to the lounge in the afternoon for activities and residents were seen to come in plenty of time. The activities coordinator was observed to ‘round residents up’ to come to the activities and this includes motivating and encouraging residents who need support.  Currently the activities records are kept by the activities coordinator in a separate file (link 1.3.3.4). |

##### **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:** PA Moderate |
| **Evidence:** |
| D16.3c: All initial care plans are developed by the nurse manager of registered nurse within the first 24 hours following admission and the long term care plan documented within three weeks of admission. All care plans are reviewed at least six monthly– sighted in five of five files reviewed.  There is a three monthly review documented by the GP.  D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated An improvement is required to updating of the care plan or documentation of a short term care plan when changes occur. |

##### **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:** PA Moderate |
| **Evidence:** |
| The problem page and the progress notes are used to document changes in condition. The issues are documented with some interventions noted. Examples of changes for residents include the following: a) rapid deterioration in condition for one resident over the past seven days – updated on the day of the audit; b) skin tears for one resident with frequent falls. |
| **Finding:** |
| The care plan or a short term care plan is not completed or updated to reflect the issue due to the changes, interventions and evidence of ongoing review. |
| **Corrective Action:** |
| Update the care plan and/or document a short term care plan when changes occur for a resident. |
| **Timeframe (days):** 60 *(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:** PA Moderate |
| **Evidence:** |
| There are policies and processes that describe medication management that align with accepted guidelines. The medication policy covers all aspects of medicine management i.e. prescribing, dispensing, administration, review, storage and disposal.  Medications are checked against the doctor's medication profile on arrival from the pharmacy by a registered nurse. Any mistakes by the pharmacy are regarded as an incident.  Designated staff completed annual medication competencies – checked with confirmation that these are completed during the review of staff files.  The register which shows signatures/initials to identify the administering staff member. Resident medication charts are identified with demographic details and photographs.  Allergies are identified on the medication form by the doctor and matches the resident record.  All 10 medication charts reviewed have allergies (or nil known), documented. The service documents adverse reactions and errors on incident/accident forms. There is a locked cupboard that is used for controlled drugs with evidence that weekly stocktakes are completed and balances match.  There is a drug trolley that is kept in the nurses’ office when not in use. A medication round observed indicates that all practice is appropriate as per the policy. There is a policy and process that describes self-administered medicines. There are currently residents who self-administer medication and two reviewed have a self-administration competency signed off by the doctor confirming competence. There is no evidence of transcribing. D16.5.e.i.2; Nine of the ten medication charts/review of consultation notes identified that the GP has seen the reviewed the resident three monthly. Residents keep their own doctor and visit the doctor themselves for the most part. Often family are involved in taking them. There are two doctors who visit the facility three monthly or as necessary and the general practitioner interviewed states that they do not visit other residents if they are not part of their practice. The registered nurse states that the medication sheets are sent with the resident to the doctor to sign off. Improvements are required to the following: dating of eye drops etc., the process of checking for expired medication/damaged packaging and transcribing. |

##### **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:** PA Low |
| **Evidence:** |
| Some topical applications e.g. eye drops that include an expiry date are dated.  There is a process to ensure that any medications that have expired or have damaged casing are returned to pharmacy. |
| **Finding:** |
| (i)Three eye drops currently in use are not dated. (ii) Three drugs are expired and one has a cracked base but is still on the shelf. |
| **Corrective Action:** |
| (i)Date all topical medications that have explicit expiry dates from when opened. (ii) Ensure that all medication is in safe containers and that these have not expired. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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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:** PA Low |
| **Evidence:** |
| PRN charts and administration signing forms are correctly completed with no evidence of transcribing. The registered nurse transcribes instructions for medication on the resident medical data form on admission and at times include instructions for administration of medication in the progress notes. |
| **Finding:** |
| Registered nurses transcribe instructions around medications on the resident medical data form. |
| **Corrective Action:** |
| Cease the practice of transcribing of instructions for administration of medication. |
| **Timeframe (days):** 30 *(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:** PA Low |
| **Evidence:** |
| The service has a workable domestic kitchen based in the village. The kitchen and equipment is well maintained. The service employs one cook and one chef with kitchen assistants and students at night to transport the food. All food is transported to the dining room/kitchen in the rest home in a hot box and the staff place the containers in the bain marie and serve from these.  D19.2 Staff in the kitchen have completed food safety and Ecolab training.  There is a winter/summer menu (currently using the summer menu) and a dietician review of the menu has been completed in September 2013.  Diets are modified as required and the rest home staff have copies of food preferences and any specific dietary needs. Staff at the rest home complete a 24 hour food order for the residents and this is provided to the kitchen the day before. Two caregivers and the registered nurse confirm that one resident has a gluten free diet and one has an allergy to mushrooms. The whiteboard in the kitchen has a note of the gluten free diet only.  There is a choice of foods and the kitchen can cater to specific requests if needed.  Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented. The service encourages residents to express their likes and dislikes. The residents interviewed were predominantly happy with the meals provided.  Equipment is available on an as needed basis. Residents requiring extra support to eat and drink are assisted and this was observed during lunch. The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires.  The chiller temperatures are checked daily and the cook is aware that other fridges and freezers should be checked. Food in the fridge, freezer and chiller is covered and dated.  Hot food temperatures are taken at the evening meal to confirm that they are cooked through and these have been recorded in 2013 until 14/12/13 and restarted when the cook came back from leave on 4/1/14. Temperatures of hot food at not taken in the rest home to confirm that they are still hot when served.  The kitchen is clean and all food is stored off the floor.  Chemicals are locked away. A food audit was last carried out on February 2013 and compliance was achieved. Staff in the rest home have been trained in safe food handling. Food handling training last occurred in February 2013. The kitchen provides meals to the village and is required to have a Council certificate. The cook interviewed is aware of the need for this.  Improvements are required to checking of hot food temperatures, monitoring of fridge/freezer temperatures, allergies and food preferences documented in the kitchen. |

##### **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:** PA Low |
| **Evidence:** |
| Staff in the rest home have access to food preferences and allergies through the nutritional assessment completed for residents. Kitchen staff have a white board and one special diet is recorded.  Two staff and the registered nurse confirm that there is a resident with a gluten free diet and allergy to mushrooms.  Staff in the rest home serve food and state that there is always an alternative for the resident if mushrooms are served. |
| **Finding:** |
| Kitchen staff do not have a copy of allergies and food preferences in the kitchen. |
| **Corrective Action:** |
| Provide kitchen staff with a copy of allergies and food preferences to be documented in the kitchen. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The cook records temperatures of the chiller with these recorded at 3.8-4 deg C. The cook is aware of the need to check the temperatures of other fridges/freezers in the kitchen but states that there are no thermometers available to use. Hot food temperatures are taken at the evening meal to confirm that they are cooked through and these have been recorded in 2013 until 14/12/13 and restarted when the cook came back from leave on 4/1/14. Temperatures of hot food at not taken in the rest home to confirm that they are still hot when served. |
| **Finding:** |
| (i)While there is evidence of checking of hot food temperatures, this has lapsed during the leave period of the cook. (ii) Monitoring of fridge/freezer temperatures is not taken in the kitchen. |
| **Corrective Action:** |
| (ii)Check hot food temperatures consistently. Ii) Monitor fridge/freezer temperatures to ensure that they are in the correct range. |
| **Timeframe (days):** 90 *(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:** |
| The building holds a current warrant of fitness - expiry date 28/7/14.  There are two wings and operational areas in the service and all are fully functional  The facility has a van available for transportation of residents. Those staff transporting residents hold a current first aid certificate.  The maintenance programme ensures all buildings, plant and equipment are maintained to an appropriate standard or specification where a standard exists for example a planned maintenance system, reactive maintenance system, list of equipment requiring calibration and current calibration reports. In the facility, residents are able to bring in their own possessions and are able to adorn their room as desired. Consideration is given to residents when purchasing new furniture/equipment.  There are outside areas that include shade around the facility and one resident in particular was observed to use the outdoor areas during the day. ARC D15.3; The following equipment is available: shower chairs, lifting belts.  There is a lounge and dining area and other rooms/areas where residents can have private space if required.  There are no obvious signs of areas needing repair during the tour. |

##### **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.)* |

##### **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.

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

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

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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 8134.2:2008: 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 policy around restraint and enablers is applicable to the type and size of the service (rest home). The service has a policy of non restraint and there are no enablers or restraints in use on the day of the audit.  The policies and procedures are comprehensive, including definitions, processes and use of enablers. The policy includes that enablers are voluntary and the least restrictive option.  Staff have had training around challenging behaviours, restraint and enablers last in March 2013. Two caregivers interviewed, the nurse manager and the registered nurse interviewed confirm knowledge of restraint, enablers and management of challenging behaviours. |

##### **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:** |
| The infection control surveillance policy describes the surveillance programme. The infection control committee meets six weekly (staff meeting). (Meeting minutes sighted for 2013).  A monthly infection summary report is completed that includes use of antibiotics and follow up required if needed.  There is a monthly graph documented and a record kept of specimens sent to the laboratory with results.  Trends and individual outcomes are noted and acted upon by the service as described by the nurse manager.  Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the residents. A separate summary is kept of location of infections and this is analysed year to year. The monthly trends and analysis summary also records improvements e.g. encouragement to staff to report at handover to increase fluid intake and assess for health issues, documentation reminders and registered nurse reminders to administer medications.  The infection control coordinator is a designated registered nurse with the nurse manager (registered nurse) providing overall responsibility.  Staff interviewed including two caregivers, the enrolled nurse and the nurse manager confirm knowledge of best infection control practice and of surveillance data. There have been no outbreaks of infections since the last audit as confirmed by the nurse manager interviewed. |

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