

The Cascades Retirement Resort Limited

Current Status: 30 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

Cascades Retirement Resort expanded its service scope and size in May 2013, when it added a new wing with 32 bedrooms and facilities designed as suitable for hospital level care. On the day of this unannounced audit there were 62 residents on site. Twenty-two are assessed as requiring hospital level care and 40 requiring rest home level care. There is additionally, one resident living in the attached apartment complex receiving rest home level care.

This audit revealed that five of the six requirements from the 2013 provisional audit are resolved and that five of the six requirements for improvement from the 2012 certification and verification audit are also resolved. There are ongoing required areas of improvement related to initial nursing assessments and improvement related to the food and nutritional needs of individual residents.

Audit Summary as at 30 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

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

Consumer Rights as at 30 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 30 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 30 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 medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 30 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.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 30 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 30 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 3.91)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	The Cascades Retirement Resort Limited
Certificate name:	The Cascades Retirement Resort
Designated Auditing Agency:	DAA Group Ltd
Types of audit:	Surveillance
Premises audited:	55 Pembroke St, Melville Hamilton
Services audited:	Rest Home and Hospital
Dates of audit:	Start date: 30 January 2014 End date: 30 January 2014
Proposed changes to current services (if any):	

Total beds occupied across all premises included in the audit on the first day of the audit:	62
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Audit Team

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

Sample Totals

Total audit hours on site	16	Total audit hours off site	10	Total audit hours	26
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Number of residents interviewed	6	Number of staff interviewed	8	Number of managers interviewed	1
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	1
Number of medication records reviewed	12	Total number of staff (headcount)	80	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	

Declaration

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

I confirm that:

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

Dated Wednesday, 12 February 2014

Executive Summary of Audit

General Overview

Cascades Retirement Resort expanded its service scope and size in May 2013 when it added a new wing with 32 bedrooms and facilities designed as suitable for hospital level care. On the day of this unannounced audit there were 62 residents on site. Twenty-two are assessed as requiring hospital level care and 40 requiring rest home level care. There is additionally, one resident living in the attached apartment complex receiving rest home level care.

This on site audit revealed that five of the six requirements from the 2013 provisional audit are resolved and that five of the six requirements for improvement from the 2012 certification and verification audit are also resolved. There is an ongoing required area of improvement related to initial nursing assessments and an unresolved area requiring improvement related to the food and nutritional needs of individual residents.

Outcome 1.1: Consumer Rights

The service adheres to the principles of open disclosure and notifies residents and their families where necessary and appropriate, of any matters that may impact on them.

The service is managing the complaints process effectively. There have been no complaints to the Office of the Health and Disability Commissioner. The complaints register contains a clear account of the details for each complaint received by the service and how these are acknowledged, investigated and resolved. Residents and relatives are informed and demonstrate knowledge and understanding about the complaint management processes.

Outcome 1.2: Organisational Management

There are no changes to the ownership/governance or management of the Cascades Retirement Resort since the previous audits. Quality and risk management systems and processes are well established and are being maintained. All adverse events are reliably reported and recorded.

Staff are recruited, supported in their professional development, and are managed effectively. Staffing levels are appropriate for the number and needs of residents. The requirement from the provisional audit to ensure an adequate number of suitably skilled and experienced staff are on site 24 hours a day has been addressed.

Outcome 1.3: Continuum of Service Delivery

The provision of services is delivered by suitably qualified and experienced staff. The registered nurse conducts the initial assessment and initial care plan on the resident's admission to the service. There is an ongoing improvement required to ensure there is documented evidenced of the completion of the initial care plan. The provision of care is based on the assessed needs of the resident, for residents at either rest home or hospital level of care. Since the previous certification audit the service have made improvements in ensuring the initial nursing assessment and ongoing medical reviews are conducted within time frames that comply with contractual requirements. There is an ongoing required improvement to ensure there is documented evidence that the residents are reviewed by a medical practitioner within two days of admission, when this is required. The previous area for improvement to ensure the care plans reflect the needs of the residents and describe the interventions required to achieve the resident's goals has been implemented.

The activities are planned to meet the needs and strengths of the residents.

The menu is reviewed by a dietician as suitable for the older person living in a care facility. The review of satisfaction surveys, interviews with residents and the ongoing resident feedback indicate that the service is identifying resident dissatisfaction with some aspects of the food service; this is identified as a required area for improvement.

A safe medicine management system is observed on the day of audit. Staff who are responsible for medicine management are assessed as competent to perform the role. The area requiring improvement from the previous certification and provisional audits, related to ensuring a safe and appropriate medication management system, has been addressed.

Outcome 1.4: Safe and Appropriate Environment

The buildings, chattels and equipment are being maintained in excellent condition and are safe and suitable for the services provided. There is a current building warrant of fitness. There is evidence that trial fire evacuations are being regularly conducted to good effect and that the previous requirement related to this from the provisional audit is now resolved.

Outcome 2: Restraint Minimisation and Safe Practice

There are two hospital level care residents who require restraint interventions (eg, bed rails). There are no enablers in use. The service demonstrates that it uses safe and appropriate restraint.

Outcome 3: Infection Prevention and Control

The service has an appropriate system for the surveillance of infections that reflects the size and scope of the service. Where the infection

rates are higher than expected the service implements a risk management plan to address any shortfalls identified.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	16	0	1	1	0	0
Criteria	0	41	0	1	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	32
Criteria	0	0	0	0	0	0	0	58

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	The initial care plan development date was not able to be verified in three of the six files reviewed. Two of the six files reviewed have the initial medical review recorded at a period greater than	Ensure there is a documented record of the initial care plan being completed on admission. Ensure the initial medical review is conducted within two working days, when this is required.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				two working days.		
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 1.3.13.1	Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	Five of the six residents interviewed at the time of audit report dissatisfaction with some aspects of the food service. The sighted satisfaction surveys and complaints process record ongoing feedback with quality aspects of the food services.	Review nutritional needs and resident feedback to ensure the needs of the residents are met.	180

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:

The service has procedures in place to ensure residents, and where appropriate, family/whanau, have a right to full and frank information and open disclosure from service providers. The two of two family member interviews confirm they are kept informed of the resident's status, including any events adversely affecting the resident. A family contact sheet is held in each resident's file. Evidence of open disclosure is documented in the family contact sheets, on the accident/incident form and in the residents' progress notes (evidenced in six of six residents' files).

Wherever necessary and reasonably practicable, interpreter services are provided.

The ARC requirements are met.

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:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

Attainment and Risk: FA
Evidence: The systems in place continue to ensure consumers are advised on entry to the facility of the complaint processes. Residents and family interviewed demonstrate an understanding and awareness of these processes. As per the requirement in ARC D13.3h, complaints procedures are included in the admission agreement. The complaints register is being maintained. There have been no complaints to the Health and

Disability Commissioner since the previous audits in 2012 and 2013. The register contains details of 16 written and verbal complaints received in 2013 and one in 2014. There is evidence each complaint has been fully investigated, and that the complainants where known, are acknowledged and kept informed during investigations. Each complaint has been resolved and outcomes are reported to the owner/operator and staff appropriately (confirmed by interview with staff and the general manager (GM). Documents sighted and staff interviewed (eg, three registered nurses (RN)s, health care assistants (HCA) the quality co-ordinator and GM) demonstrate that processes are appropriately adhered to. The documented complaints policies and procedures are compliant with Right 10 of the Code

Complaint forms are readily accessible and/or displayed. Staff attend regular education on the Code of Rights including complaints processes. Review of resident meeting minutes provides evidence of discussion on the Code of Rights and complaints. The management of complaints meets the ARC requirements and this standard..

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service has a current and updated quality business risk and management plan which identifies the organization's quality goals, objectives, and scope of service delivery, including the service values, mission statement and philosophy and refers to quality activities and review processes. Staff and resident meetings are held on a regular basis and meeting minutes are available for review by all staff. The general manager provides the directors with monthly reports which include commentary on quality and risk management, occupancy, HR matters, quality improvements, internal audit outcomes, and clinical indicators.</p> <p>The general manager, and team leaders for the rest home and hospital wings are suitably qualified and experienced (review of personnel files and interviews with the same). The manager and team leaders are registered nurses who maintain and update their skills and knowledge on</p>

current best practice. All registered nurses and enrolled nurses (13 RNs two of those being casual and two EN) have current practising certificates as confirmed by review of the professional staff register.

This audit included assessing the provision of rest home level care to residents in the attached apartments. Evidence related to this is in part three of the report. The service meets the requirements of the ARC in regards to governance.

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

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

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

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

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

Standard 1.2.3: 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

Attainment and Risk: FA

Evidence:

Quality and risk activities are co-ordinated by an EN quality co ordinator with input from the RN Manager and delegated staff on the quality committee. Quality and business activities are well integrated across all aspects of service delivery (confirmed by a sample of recent meeting minutes (staff meetings, quality committee meetings, resident and RN meetings)). Staff interviews (two RNs, an activities co-ordinator, the quality co ordinator, health care assistants, maintenance, and kitchen staff) confirm they are kept informed and have understanding and involvement in quality and risk systems.

Interviews with six residents and two relatives confirm that they are actively consulted through surveys, frequent one-to-one discussions with staff, and at regular care evaluation meetings. The results of the annual resident/relative survey's conducted November 2013 reveal a number of opportunities for improvement. These are documented and improvements are currently being implemented. The quality co-ordinator states the effectiveness of these will be tested by re-surveying residents in the next three months.

Internal audits are co-ordinated by the quality co-ordinator who is an enrolled nurse. The sighted schedule for 2014 along with results from internal audits completed for 2013 demonstrate that all areas of service delivery are monitored and where deficits are identified these are addressed by implementing corrective actions. Quality and risk management issues and quality improvement data is reported at quality meetings and at staff meetings. Meeting minutes reviewed demonstrate that quality and risk issues, including numbers of events, are being discussed at these meetings (eg, accident/incident/event reporting outcomes, complaints, audit outcomes, infection control, health and safety, and restraint usage). Processes are in place for the collection of key performance and risk data, such as accident / incident data (reported by type, and time of event), complaints data, and infection data. There is a clear and easily understood system for data collection and analysis of accident / incidents, complaints, and infections.

Organisational risk is monitored by the operators and the general manager. (confirmed by interview with GM and review of monthly reports to owners/operators)

Health and safety policies and procedures are documented and health and safety is discussed at three monthly health and safety committee and other staff and quality meetings. Environmental audits for safety are conducted regularly and reactive facility maintenance occurs. Chemical safety data sheets, which identify hazardous chemicals, are available. The accident/incident reporting system is reliable and effective. Staff orientation/induction and the education programme includes information on health and safety. Specific risk assessment tools are utilised in service delivery plans to identify and manage clinical risk . Six residents' files sampled demonstrate that clinical risks are identified in the service delivery plans, that informed consent has been obtained and that there is multidisciplinary team input. Any identified hazards are reported and the hazard register is current and kept updated (sighted and interview with

maintenance staff).

The service meets the ARC requirements in regards to quality and risk management.

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

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

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

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

Criterion 1.2.3.4 (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.

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

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

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

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

Criterion 1.2.3.6 (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.

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

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

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

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

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

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

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

Criterion 1.2.3.9 (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.

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

Standard 1.2.4: 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:

The adverse event reporting system is well established and effective. Analysis of events/incidents and accidents is conducted by the quality co-ordinator.

The incident register and a sample of incident reports reviewed on site, reveal a systematic approach to collecting and collating incident data (eg, different coloured incident report forms are used for medicine errors and staff injury and all incidents are collated according to either hospital or rest home, the type of incident, the time it occurred and whether there was an injury or not). The service reliably identifies high or 'serial fallers'. There is a recent spike in pharmacy dispensing errors (average 10 a month) and nurses are maintaining reliable quality controls. Two senior clinicians check all incoming medicines and send an immediate faxed list of errors back to the pharmacy. A meeting has been requested with the pharmacy supplier to resolve the ongoing (three months) problem of packaging errors. The quality co-ordinator has recently initiated a post falls analysis project as a first step to gaining more insight to falls which will then assist in the development and implementation of a new falls prevention and management programme. Family members are consistently contacted following adverse events involving the consumer (confirmed by review of incident reports and interview with two relatives) in accordance with the service open disclosure policy.

Staff confirmed during interview that they are made aware of their essential notification responsibilities through job descriptions, policies and procedures and professional codes of conduct. Policy and procedures comply with essential notification reporting (eg, health & safety, human resources, infection control).

The service meets the ARC requirements.

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <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.

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

Standard 1.2.7: 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

Attainment and Risk: FA
Evidence: Good employer practices in relation to staff recruitment, development and management are well established. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority (confirmed by

review of six staff files along with employment agreements, completed police checks, orientation and competency assessments).

The sample of staff records reviewed also shows that individual training records are maintained for all staff. Annual practising certificates are current for all staff who require them (sighted in the professional registration folder maintained by the GM). The staff competency register and records of education are being maintained by the education and quality co-ordinator who is an enrolled nurse. In-service education in subject areas relevant to the services provided (eg, consumer rights, health and safety, infection prevention and control, restraint minimisation, cultural safety, emergency training (including first aid), safe manual handling and transfers and a range of subject specific education sessions on the clinical/physical and personal care of older people) is provided at least monthly (confirmed by review of the 2013 and 2014 staff training plan and attendance records for 2013). Eight staff interviews (three RNs, HCAs, activities, the chef and maintenance staff) also confirm their attendance at ongoing in-service education and the currency of their annual performance appraisals.

The previous area for improvement related to orientation/induction programme is now resolved. There is evidence that all new staff engage in an induction programme which is specific to the role they are employed for and that this includes the essential components of the service provided. The orientation programme includes information about the organisation, the quality and risk systems, policies and procedures, health and safety requirements, the physical layout of the facility, authority and responsibility of the individuals' positions, emergency preparedness and tasks specific to the role. The entire orientation process, including completion of competencies, takes three months to complete and staff performance is reviewed at the end of this period, as confirmed by interview with the GM, the EN education/quality co-ordinator and review of six files, which includes four new staff.

The service meets the ARC requirements.

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.

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

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

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

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

Criterion 1.2.7.4 (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.

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

Criterion 1.2.7.5 (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.

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

Standard 1.2.8: 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: <p>Staffing numbers and skill mix continue to be planned according to resident numbers and their dependency levels and needs (confirmed by interview with the GM, two team leaders and the quality co-ordinator. There are sufficient numbers of qualified RNs and health care assistants to provide a 5:1 hospital resident to staff ration and a 10:1 rest home resident to staff ratio.</p> <p>The hospital RN Team Leader is on site 8.30am to 4.30pm Monday to Friday and the current rest home RN team leader works 24 hours a week (three eight hour morning shifts). The rest home wing is staffed by another senior RN for the other four days. The RN general manager is on site four days a week. There are six staff on night duty. Three are in the rest home and two in the hospital and one runner who is based in the hospital.</p> <p>Staff allocation in each area is as follows: 1) Rest Home: maximum capacity 42 beds AM shift: There are five five health care assistants (three from 7am to 3.30pm and two from 7am to 12 or 1pm) Plus the EN educator/quality</p>

co ordinator three days a week. A senior HCA is rostered to provide care to apartment residents 7am to 1pm seven days a week.
PM shift: 3.15pm to 11.45pm Two health care assistants and a senior HCA plus an extra HCA from 3.30pm to 8.30pm.
Night shift: One EN and two HCA's 12am to 7am and 12am to 8am.

2) Hospital wing: maximum capacity 32 beds

AM shift: There are two RNs and five health care assistants 7am to 3.30pm

PM shift: 3.15pm to 11.45pm Two RNs and four health care assistants (two from 3.30 to 9pm and two from 3.30 to 12pm)

Night shift: One RN and two HCA's 12am to 7am and 11.30pm to 7.30am.

There is an additional float HCA on site from 12am to 7am each night

The head diversional therapist/activities co ordinator is employed five days a week and is on site from 9am to 5.30pm Monday to Friday each week. There are another two other part time employed support activities personnel. Auxiliary staff (eg,cooks, cleaners, laundry personnel and maintenance staff) are employed for a suitable number of fixed hours and duties seven days a week.

Rosters and actual hours worked by staff sighted for the previous month confirm sufficient staff cover and that there are enough casual/available staff who can be called in when necessary. Six residents interviewed report staff answer their call bells in a timely manner and that the care they receive is appropriate to their needs. Two health care assistants interviewed (who work different shifts) report there is adequate staff available and that they are able to get through their work.

The service meets the ARRC requirements in regards to staffing. The corrective action from the 2013 provisional audit in regards to demonstrating adequate staffing for hospital level care is now addressed.

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: PA Moderate

Evidence:

There is a previous required improvement (CAR) at 1.3.3.3 from the certification audit in August 2012 to ensure all residents have their initial assessment completed with 24 hours of admission, to have the initial care plan developed within 48 hours of admission, and to have the long term care plan developed within three weeks of admission. The residents are reviewed by the GP within two days of admission where required and ensure at least three monthly GP reviews. An ongoing CAR remains for ensuring the initial medical reviews are conducted within two working days, where required and ensuring the initial care plan is developed on admission. As this is an ongoing corrective action the risk rating has been increased to moderate. The other areas identified for improvement are now addressed and improvements implemented.

The service has not yet commenced the use of the interRAI assessment, with the RNs scheduled for training in February 2014. The current paper based initial assessments include personal support needs, communication, diet, fluids, culture, spirituality, sexuality, mobility, pain relief, cognition, continence, skin and wound. The initial assessments also include pressure area risk, body chart for skin integrity, separate pain assessment, mini nutritional assessment, falls risk, geriatric assessment scale, manual handling assessment and a bladder chart. There is an initial care plan used for up to three weeks until the long term care plan is developed (refer to CAR at 1.3.3.3). The service utilises a standardised long term care plan which is individualised to the resident's needs, their own individual long term care plan for other identified needs and short term care plan for temporary changes. The long term care plans identify the problem, aim, solution/interventions and review/evaluation. The needs identified on the long term care plan include assistance with personal care agreed with the resident (and where applicable the family), mobility, food and nutrition, continence, physical problems, rehabilitation, mood, sexuality and intimacy, social, cultural and recreational needs. Short term care plans identify the problem, aim, solution and review to evaluate if the interventions are working. The long term care plans record those who are consulted to contribute to the care planning (eg, resident, family, staff, key worker, diversional therapist, occupational

therapist and physiotherapist). The six of six residents' files reviewed (three hospital and three rest home, which includes the file of one rest home level of care resident living in the apartments) have the appropriate assessments, care plans and desired goals identified.

Interview with the RN confirms that the initial assessment and initial care plan are developed on the day of admission, the long term care plan is developed within three weeks and reviewed and evaluated at least six monthly. The initial care plan is not sighted in three of the six residents files reviewed (refer to CAR at 1.3.3.3). The residents are reviewed by a general practitioner (GP) at least three monthly, when the resident is assessed as stable. Two of the six residents files reviewed have the initial review by the GP recorded at greater than two working days; this is an ongoing area for improvement. The GP is not available for interview at the time of audit. The five of five residents interviewed report a high satisfaction with the medical coverage and feel they are able to access the GP when they require.

Each resident has one file which includes the multidisciplinary team input into care. A daily record of care records interventions each shift. There is verbal handover between each shift. A communication book is also maintained to record appointments. The three RNs and one caregiver report that there is an adequate handover to provide information for the continuity of care and report an excellent team approach to care.

Tracer example one – rest home level of care

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

Tracer example two: A hospital level of care resident

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

The six of six residents (four hospital and two rest home) and two of two family/whanau interviewed report high satisfaction with the care provided at the service.

The ARC requirements for D16.2b and D16.5e..i. are partially met. The remaining ARC requirements are met.

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

Criterion 1.3.3.3 (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.

Attainment and Risk: PA Moderate
<p>Evidence:</p> <p>The initial care plan in the file of the rest home resident reviewed and two other supplementary resident files, do not have a copy of the initial care plan in their file. The RN and manager report that they are certain the initial care plans are completed for these residents. These initial care plans were not located in the current or archived files at the time of audit. The remaining three resident files reviewed have initial care plans developed on the day of admission. The first medical review of a rest home resident is not recorded in the resident's file till six weeks after admission. One other resident file reviewed does not have the first medical review recorded till five weeks after admission. The RN reports that for some residents who maintain their own GPs, the service may not have a documented record of the GP visit in the resident's file. Corrective action requests are made to ensure there is a documented record of the initial care plan and a documented record of the initial medical review to ensure these are conducted in time frames that comply with meeting the residents' needs and contractual time frames.</p>
<p>Finding:</p> <p>The initial care plan development date was not able to be verified in three of the six files reviewed. Two of the six files reviewed have the initial medical review recorded at a period greater than two working days.</p>
<p>Corrective Action:</p> <p>Ensure there is a documented record of the initial care plan being completed on admission. Ensure the initial medical review is conducted within two working days, when this is required.</p>
Timeframe (days): 90 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a previous CAR at 1.3.5.2 identified at the last certification audit to ensure all identified needs of the resident are addressed in the care plans. This is now addressed and an implemented improvement since the certification audit. The six of six care plans reviewed describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: FA
Evidence:

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

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Attainment and Risk: FA
<p>Evidence:</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The six of six care plans reviewed (three rest home and three hospital), record interventions that are consistent with the residents' assessed needs and desired goals. Observations on the day of audit indicate residents are receiving care that is consistent with the residents' needs. The six of six residents and two of two family/whanau interviewed report that the service meets the needs of the residents. The file of the rest home resident reviewed shows interventions are changed in response to their condition with specific interventions mobility, nutrition and continence. The hospital resident reviewed has the intervention for mobility changed to reflect the resident's changed needs. The interventions put in place to meet residents' needs are monitored by staff. The file of a resident who has had a previous pressure area has a pressure relieving mattress on their bed. The wound assessment and wound care log record the interventions for the wound care.</p> <p>The six of six residents (four hospital and two rest home) and two of two family have high praise for the interventions at the service.</p> <p>The ARC requirements are met.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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 activities co-ordinator reports activities plans are individualised to the resident's needs. The activities are individualised and developed in conjunction with the resident and where appropriate their family. The activities assessments and plans are incorporated in to the long term care plan, as sighted in the residents' files reviewed, evidence shows they are up to date and reflect individualised needs of the residents. The activities assessment include social pursuits, intellectual interests, creative pursuits, physical activity, and outdoor interests.

A monthly activities plan (sighted) is developed based on the resident's needs, interests, skill and strengths. The activities cover cognitive, physical and social needs. For variety, there is a theme for each month with community events that are occurring locally included in the programme.

The six of six residents' files reviewed have activities and social assessments. The goals are updated and evaluated in each resident's file at least six monthly with person centred care plan reviews and multi-disciplinary reviews. The activities co-ordinator reports where residents have a specific need, the service endeavours to provide the resources for this.

Where possible residents' independence is encouraged to maintain links with family and community groups. Residents are provided with outings on a routine basis. One to one activities are planned to meet the resident's interests.

The six of six residents interviewed report they enjoy the range and variety of planned activities.

The ARC requirements are met.

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

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

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

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA
Evidence: <p>The five of six care plans reviewed evidence evaluations are recorded at least six monthly by the manager (RN), with input from the GP, the resident, the family and the activities coordinator. The remaining file has an admission under six months, and has more frequent evaluations in the mobility, nutrition and continence management components of care, to reflect the changed needs of the resident. The documented evaluations indicate the resident's progress in meeting goals, and care plans are updated to reflect progress towards meeting goals.</p> <p>Where progress is different from expected the service either updates the long term care plan or uses short term care plans for temporary changes. The six of six residents' files reviewed indicate they are updated to reflect changing needs of the resident. The five of five residents and two of two family/whanau interviewed report involvement in the evaluation process and are satisfied with the care provided.</p> <p>The ARC requirements are met.</p>

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

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

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

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

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

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

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Attainment and Risk: FA

Evidence:

There were previous corrective action requests at the previous partial provisional audit at 1.3.12.1 and 1.3.12.6 to implement safe and appropriate medicines management upon commencement of service delivery. These were fully implemented when the services commenced.

There is a previous CAR from the last certification audit at 1.3.12.1 to ensure eye drops are dated when opened, ensure all medications are signed for as they are administered, ensure all medications charts are administered as prescribed and ensure all alternative remedies are charted by the GP. These are now addressed and areas of improvement implemented since the last certification audit.

Medicines for residents are received from the pharmacy in the robotic sachet delivery system. The signing sheet that records the sachets are checked for accuracy against the resident's medicine chart. A medicine reconciliation process occurs with new admissions and when the resident has been to a specialist or hospital admission. A safe system for medicine management is observed on the day of audit. Also refer to standard 1.2.4 regarding the incidents for medication errors.

Medicines are stored in locked medicine trolleys and in the locked treatment rooms in both the rest home and hospital sections of the service. There is a monthly stock rotation recorded for the medicines that are not packed in the sachets. The controlled drugs are stored in a locked safe, two staff sign the register at each administration and a weekly stock count is undertaken. The service's medicine fridge is monitored at least weekly and temperatures are within recommended guidelines.

The 12 of 12 medicine charts reviewed are reviewed by the GP in the last three months, this is recorded on the medicine charts. All prescriptions sighted contain the date, medicine name, dose, time of administration with any allergies highlighted in red ink. All medicine charts reviewed have each medicine individually prescribed. All signing sheets are fully completed on the administration of medicines for the past four weeks.

There are documented competencies sighted for the staff designated as responsible for medicine management.

The RN reports that there are no residents assessed as competent to self-administer their medicines. The service has a self-administration competency for residents who are able to self-administer their medicines.

The ARC requirements are met.

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

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

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

Criterion 1.3.12.3 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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.

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

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

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

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

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

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

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

Attainment and Risk: PA Low

Evidence:

There were previous corrective action requests at 1.3.13.1 and 1.3.13.2 to ensure the food provided complies with the current MoH food and nutritional guidelines for older people, and that residents' food, fluid and nutritional needs including their food preferences and eating abilities are assessed and met, upon commencement of service delivery. The six week rotating menu, with seasonal variations, is approved by a registered dietician in April 2013 as suitable for aged care residents. The menu review is based on the dietician NZ audit tool for residents living in long term care. A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. For example, the service provides diabetic and texture modified diets to meet specific residents' needs. The care staff manage the additional food supplements for the residents (eg, Fortisip). Refer to CAR at 1.3.13.1 regarding meeting the residents' needs.

All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer are in their original packaging or labelled and dated if not in the original packaging. Staff have undertaken food safety management education appropriate to service delivery.

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: PA Low

Evidence:

One of the six residents interviewed reports that the food and fluids are of a high standard. Interviews with five of the six residents and two of two family/whānau report dissatisfaction with the overall quality of the meat. Four of these residents did report that the quality of other food is satisfactory to very good. These four residents did report that they provide feedback to the manager when they are not satisfied with the quality of the meal, and feel that they are listened to and the manager investigates the complaint. One resident reports that they are not satisfied with all aspects of the meal service. One resident and family/whānau report that the resident was initially on a soft diet, but found this unpalatable and described the look and taste of the textured modified diet as 'like cat food'. The resident and family satisfaction survey conducted in November 2013 has eight of 29 of the respondents reporting dissatisfaction with the some aspect of the food service. At interview with the manager and cook, they have implemented ongoing review of the quality of the meals. The cook reports that they attended the monthly resident meeting and has weekly discussions with residents regarding the meals. Management advise that the cook is asked to attend these monthly meetings, but states that the cook has not attended.

Finding:

Five of the six residents interviewed at the time of audit report dissatisfaction with some aspects of the food service. The sighted satisfaction surveys and complaints process record ongoing feedback with quality aspects of the food services.

Corrective Action:

Review nutritional needs and resident feedback to ensure the needs of the residents are met.

Timeframe (days): 180 (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:

Finding:

Corrective Action:

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

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

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

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 1.4: 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

Attainment and Risk: FA

Evidence:

There is a current building warrant of fitness which expires on 24 May 2014. Interview with maintenance personnel and site inspection reveal the buildings, plant and equipment situated inside and outside the facility are in excellent working condition.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

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

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

Attainment and Risk: FA
Evidence: The previous action required related to the need to demonstrate that staff receive information and training in fire and safety emergency procedures is now resolved. Staff training records, interview with staff and detailed records show that staff on all shift attend regular trial evacuations/fire drills. These are conducted in both wings at least six monthly and the education co-ordinator monitors and checks that all staff attend at least one of these each year.

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

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

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

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

Attainment and Risk: FA
Evidence: There are two hospital level care residents who require restraint interventions (eg, bed rails). There are no enablers in use. The service demonstrates that it uses safe and appropriate restraint as confirmed in interview with two RN team leaders and review of two residents' files.

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

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

Standard 3.5: 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:

Infection control data is collected on urinary tract infections, chest infections, wound infections, eye and ear infections and multi-resistant organisms. The surveillance data is gathered for the rest home and hospital level of care residents. The monthly report of collected data is provided to senior management and presented at quality and staff meetings. The surveillance data collected is based on guidelines from an aged care consultant. Infection control data is included in the quality audit programme.

The infection prevention and control officer has recently been appointed to the role (January 2014). All care staff members are responsible for the reporting of suspected infections to the infection control co-ordinator. The infection control co-ordinator is responsible for ensuring appropriate action, notification and follow-up is undertaken. The data sighted for November 2013 records three hospital residents with urinary tract infections, with the analysis recording that all these residents are immune compromised and prone to UTI despite good fluid intake, hygiene care and close monitoring. The data also records an increase in skin infections for the rest home residents (5 residents with skin infections), the analysis records that two of these infections are chronic conditions and three of the infections are managed with regular dressing and antibiotics. The analysis records the ongoing staff education.

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

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

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

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