# Kirsty Schofield

## 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

Cornwall Rest Home is a 27 bed facility in central Masterton. It is owned and operated by Kirsty and Craig Schofield. Five areas requiring improvement were noted at certification audit in 2012. These are all now addressed. No new areas for improvement are identified at this spot surveillance audit.

Services are provided by a team of staff, including registered nurses (RNs), caregivers, domestic staff and cooks. Resident satisfaction results are very favourable and are monitored annually. Contractual requirements are met in the delivery of services at Cornwall Rest Home.

## 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 |
|  | 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. |

### 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. |

### 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. |  | Standards applicable to this service fully attained. |

### 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. |

### 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. |

### Infection Prevention and Control as at 30 January 2014

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

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Cornwall Rest Home |
| **Certificate name:** | Cornwall Rest Home  |

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

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance |
| **Premises audited:** | Cornwall Rest Home, 3 Cornwall Street, Masterton |
| **Services audited:** | Rest home care |
| **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:** | 25 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **Total hours off site** | 8 |
| **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 | 16 | Total audit hours | 32 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 3 | Number of staff interviewed | 7 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 3 | Number of staff records reviewed | 8 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 23 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, Managing 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 Thursday, 20 February 2014

## **Executive Summary of Audit**

|  |
| --- |
| **General Overview** |
| Cornwall Rest Home is a 27 bed facility in central Masterton. Five areas requiring improvement were noted at certification audit in 2012. These are all now addressed. No new areas for improvement are identified at this spot surveillance audit. Services are provided by a team of staff, including registered nurses (RNs), caregivers, domestic staff and cooks. Resident satisfaction results are very favourable and are monitored annually. Contractual requirements are met in the delivery of services at Cornwall Rest Home.  |

|  |
| --- |
| **Outcome 1.1: Consumer Rights** |
| Open disclosure is practiced by staff members at Cornwall Rest Home. A required improvement from the previous certification audit has seen the recording of each family/whanau’s specific requests for information and contact when events occur. These requests are followed with families/whanau contacted as they have directed. There is an easily accessed complaints process, and residents and family/whanau can raise concerns at any time with staff members. A formal complaint register is maintained which meets the requirements of the standard. The 2013 resident satisfaction survey results indicate that residents’ are happy with communication and the resolution of issues they may identify.  |

|  |
| --- |
| **Outcome 1.2: Organisational Management** |
| Cornwall Rest Home is owned and operated by XXXXX and XXXXXX. They have a current business plan which identifies their mission – to provide high quality care in a homelike environment – and business objectives, which are regularly monitored. The organisation has a quality management system and risk management which is appropriate to the size and scope of the service. There is regular monitoring of all aspects of service delivery through the quality and risk management systems. Adverse events are reported and managed. Corrective actions, when required to address issues, are documented, implemented and monitored. A previously identified area for improvement in relation to the monitoring of risks on the organisation’s risk management plan is now addressed. There are policies and procedures to guide the recruitment, selection and appointment of staff, and to provide them training and information about their roles and functions. This occurs for all staff at orientation and throughout each year. The previous required improvement has been addressed. Staffing levels and the skill mix of staff is appropriate to meet the needs of residents. Staff members work as a team to ensure that each person’s needs are met and they receive high quality care.  |

|  |
| --- |
| **Outcome 1.3: Continuum of Service Delivery** |
| Two previously identified areas requiring improvement have been attended to. Care plans describe the required interventions to achieve the desired outcome as identified by the assessment process and the medication system consistently ensures the safe prescription, administration and storage of medications.Consumers participate in and receive services that are timely, planned, co-ordinated and appropriate, while being consistent with current legislative and best practice guidelines. There is evidence that residents' needs are assessed on admission by the registered nurse. All residents' files sighted provide evidence of review with the resident and their family on a regular basis. A planned activities programme exists, that develops and maintains interests and skills meaningful to the consumer, and includes a diversity of activities and involvement with the wider community. Medicine management practices are guided by well-defined medicine management policies and procedures. Practices sighted are consistent with these documents. No issues of concern are evidenced in medicine charts, recording processes and an observed administration process. Medicine records evidence medicine reviews being carried out every three monthsMenus are reviewed by a dietitian. Any special dietary requirements, needs for feeding assistance or modified equipment are recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided. |

|  |
| --- |
| **Outcome 1.4: Safe and Appropriate Environment** |
| The environment is homelike, in a well maintained villa in central Masterton. There is a current building warrant of fitness.  |

|  |
| --- |
| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are no residents with enablers in use at the time of audit. The service maintains a process to determine approval for all types of restraint, including enablers. There is a rigorous assessment process undertaken and at least six monthly reviews and evaluations of each resident who has a restraint or an enabler in use. The policy states 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”. |

|  |
| --- |
| **Outcome 3: Infection Prevention and Control** |
| Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported through all levels of the organisation, including governance. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 17 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 0 | 0 | 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 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 61 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

## **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:** |
| Cornwall Rest Home has an appropriate policy and procedure for open disclosure which meets the requirements of this standard. Each family/whanau identifies when and how they want to be notified if their relative has an incident, including the severity of the incident and the time of day in which to receive notifications. This process has been implemented in response to an area for improvement identified at the certification audit in 2012, which is now addressed. Review of recent incident reports confirms that this process is now followed. Staff interviewed during the audit (five - QA/administrator, owner/manager, one RN, and two caregivers) report this as part of the incident reporting process. Interpreter services are accessed through the Wairarapa District Health Board (WDHB) in the first instance if needed. There are no residents currently at Cornwall who require assistance from an interpreter. ARC contract 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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

#### Standard 1.1.13: 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 complaints process meets the requirements of the Code of Health and Disability Services Consumers’ Rights (the Code). It is provided to residents and family/whanau on entry to the service and is available on request. The Code is on display in the living rooms at Cornwall. People are able to raise concerns and/or complaints with any staff member at any time. At interview staff members (five) describe the way in which complaints can be reported and concerns raised and addressed by the organisation. The complaints register is maintained and can record all dates and actions taken when a complaint is lodged. The last formal complaint was made (and addressed) in 2010.ARC contract requirements are met.  |

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

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

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

##### **Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

|  |
| --- |
| **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 1.2: 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:** |
| Cornwall Rest Home has a business plan, January 2011 to December 2014. This describes their mission statement and objectives for the facility which guide their provision of services. At regular two monthly quality assurance committee (QA) meetings these objectives are regularly reviewed and monitored. The service is owned by a XXXXX and XXXXX and XXXXX is also the manager. The role of the manager is described in the business plan, and a range of position descriptions for employees are sighted. At interview the manager reports her responsibilities and accountabilities and these are appropriate to the role, and the other positions in the facility.Annual resident satisfaction survey results for 2013 were reviewed. Resident satisfaction services are high with 100% of residents being satisfied or very satisfied with their care. ARC contract requirements are met.  |

##### **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):**  *(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.

|  |
| --- |
| **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:** |
| The organisation has a quality and risk management system which is documented and is appropriate for the size and scope of the service. All requirements of this standard are met in the system and it is included in the orientation of all staff members. Evidence is sighted and reports from staff during interviews confirm that staff members understand their responsibilities in the system. Policies and procedures are developed collaboratively by the manager and QA administrator and involving other staff members. The manager and QA administrator maintain document management and ensure that all documents are reviewed on a two yearly cycle. All documents, forms and records sighted during the audit are current and have been reviewed as scheduled. Out of date versions of documents are archived and the QA administrator ensures that electronic and hard copy versions of these are removed from the current system and updated versions replace them. The quality management system monitors incidents, accidents, infections, hazards and use of restraints, to ensure that there is oversight by the QA committee of all unexpected events. QA meetings are held regularly every two months and detailed minutes are maintained which demonstrate effective monitoring of service delivery. Quality improvement is collated by the QA administrator and one of the two RNs who are assigned responsibility for this. Collated data is graphed over the calendar year with infection and incidents/accident graphs. Both the QA meeting minutes and monthly staff meeting minutes record discussion with staff members and analysis of any trends, as well as effective responses to individual residents. The quality management plan and business plan objectives are monitored during the QA meetings and notes are maintained at each meeting to record progress against each objective. Corrective action plans are developed, when needed, through the QA meeting minutes and on the internal audit summary form when all internal audits are completed. A wide range of internal audits are conducted across each calendar year, including admission processes, care plans, individual residents’ files, cleaning and laundry. There is a detailed risk management plan which is reviewed at both QA meetings and at staff meetings. A traffic light system is used to indicate a risk level against each area monitored and this is changed in response to relevant events on a monthly basis. This activity was introduced in late 2012 in response to an area for improvement and the criterion is now fully attained. The manager and QA administrator were interviewed during the audit and both demonstrate a sound understanding of their responsibilities for the quality and risk management system. A range of documents and records was also reviewed, including: QA meeting minutes for February, April, June, August, September, October and December 2013; staff meeting minutes monthly through the year; the risk management monthly review plan which indicates review of all risks monthly from October 2012. These are all current and demonstrate the effective and consistent implementation of the quality management system. ARC Contract requirements are met.  |

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

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

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

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

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

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

##### **Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

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

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

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

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

##### **Criterion 1.2.3.6 (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):**  *(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.

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

##### **Criterion 1.2.3.8 (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):**  *(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.

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

#### Standard 1.2.4: Adverse Event Reporting  **(**HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| All adverse events are reported and recorded by staff members. Events are reported on an incident/accident form or on infection surveillance reports. These are collated each month by the full time RN and the QA administrator. This collated data is reported and discussed at the monthly staff meetings and at the two monthly QA meetings. It is at these meetings that the data is graphed, with monthly data being added to the graph across the year. Any events which may impact on the service are linked to the risk management plan and this is recorded in the monthly review and monitoring of the plan. Consistent progress and notes are recorded on the plan to demonstrate the management of risks to the provision of services overall, and to individual residents. ARC contract requirements are met.  |

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

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

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

##### **Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

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

#### Standard 1.2.7: 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:** |
| Professional qualifications are validated at the appointment stage of recruitment, and annually on renewal of the person’s registration. Records maintained are for the two RNs employed by Cornwall, the GP, nurse practitioner and podiatrist who work on contract to the rest home. All hold current registrations and operate within their approved scope of practice. There are policies and procedures to guide the appointment of staff members who will provide safe services to residents. A sample of eight personnel files was reviewed during the audit, and included files for the manager, the QA administrator, both RNs, two caregivers, one cleaner/caregiver, and the cook. Records are maintained which demonstrate that the recruitment, selection and appointment systems are implemented, police checks are completed and annual appraisals are up to date. Six of these eight staff were interviewed during the audit. They report that their orientation prepared them to do their job well. As well as written information and review of policies and procedures, it included working with another staff member for a period of time before working on their own. Training opportunities are available regularly and staff report there is a good team culture where staff are supportive of one another. A previous area for improvement identified that there had been a gap in the provision of training for staff. An education plan had been developed but not implemented at the time of the certification audit. Personnel files and training records confirm that there has been a wide range of training available for staff to attend, both in service sessions, and sessions run externally by WDHB. In 2013 14 separate sessions were run, and included health and safety, fire evacuation and emergency systems, key aspects of service delivery and supporting residents (eg, infection control and wound care, medication administration, privacy, residents’ rights, advocacy, ethics, abuse and neglect, cultural safety, complaints, open disclosure, sexuality and intimacy). Topics specific to the provision of services in the aged care section include loss and grief and caring for yourself, managing the person with dementia, communication, reporting and documentation, hydration, food intake and weight loss. The previous area for improvement is now addressed. The in-service education plan for 2014 is developed and was sighted, along with an extensive programme of training available through WDHB for the year which staff report they are able to attend any relevant topics to their roles. The part time RN, who works two days a week, is responsible for the development and delivery of the annual education plan. She is also an employee at WDHB and is the nurse educator, responsible for palliative care and aged care.ARC Contract requirements are met.  |

##### **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):**  *(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.

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

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

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

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

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

|  |
| --- |
| **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:** |
| There is a policy which describes the staff levels and skill mixes in place at Cornwall. Rosters are prepared weekly, four weeks in advance. There is RN cover for 35 hours a week, and a combination of caregivers, a cleaner and cook and an activities person across weekday shifts and weekends. The two owners also provide activity support and transport at weekends and if required at other times. The rosters meet the described staffing levels and staff members report that staffing levels allow for the safe provision of services. Rosters provide for the following staff allocation across three shifts a day, each week:RNs – 1 RN 6 hours a day, Monday to Friday and on-call outside these timesMorning shift 1 caregiver 7am – 3pm, Monday to Friday1 caregiver 7am – 11am, Monday to Friday2 caregivers 7am – 3pm, Saturday and Sunday1 caregiver 7am – 1pm, Monday to Sunday Afternoon shift2 caregivers 3pm to 11pm Monday to SundayNight shift1 caregiver (awake) 11pm to 7am, Monday to SundayOther staff members are rostered on:1 activities person, 1.3pm – 4pm Monday to Friday1 of two owners 11am – 12noon, Monday to Friday and some weekends1 cook 7am to 2pm, Monday to Sunday1 cleaner 8.30am – 2pm Monday to SundayARC contract requirements are met.  |

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Admission to Cornwall Rest home is planned with the resident and the family/whanau to be at a time that is suitable to all those concerned, enabling a relaxed unhurried process where time is completely devoted to the resident/whanau. Initial pre assessment documentation that includes information from the resident, their nominated representative, the needs assessment and co-ordination service and/or previous providers of personal care services is gathered and documented by the registered nurses prior to admission, where possible. More detailed assessment, discussion and observation is undertaken by the RN on admission and documented within 24 hours of admission. This serves as the basis for care planning to cover a period of up to three weeks. The resident’s photo, their resuscitation status, current and past medical history, current medication and any allergies or sensitivities they have is documented on the front page of the care plan.The long term care plan is completed by the registered nurse, within three weeks of admission and includes the collection of more detailed assessment data. The long term care plan directs the care required to meet the resident’s need and desired outcome. The assessment, care plan and evaluation is completed and documented by the registered nurse in consultation with the resident, family and allied professionals. Assessments are evaluated every three weeks and the care plan is evaluated every six months or as needs change to ensure the appropriate care is provided and the residents’ desired outcomes are being met. Evidence of this is sighted in three of three files reviewed and verified by interviews with three of three rest home residents, three of three family/whanau members and an interview with the registered nurse and two of two caregivers. Medical assessment is conducted by the resident’s general practitioner (GP) within 24 hours of admission and the treatment programme required by the resident is documented. Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable and this is conducted by the nurse practitioner. Evidence of this is sighted in three of three files reviewed and verified by interviews with three of three rest home residents, three of three family/whanau members and an interview with the RN. The GP contracted to Cornwall rest home, who cares for 90% of the residents, and the nurse practitioner, visit twice per week to review the residents, as evidenced in documentation and verified at interview the day of audit. The GP and nurse practitioner commended Cornwall on the care they provided. The GP is on call each weekend and the nurse practitioner is on call Monday to Friday 24 hours per day.  Family contact is documented on the family contact form and this is sighted. There is consent from the resident’s contact person to establish where family members request not to be contacted regarding accidents or incidents, the level of contact and notification they require, including method of contact and time of day they wish to be contacted. Three of three family members interviewed were kept well informed of events at Cornwall rest home.Three of three residents and three of three family/whanau interviewed are happy with the quality of care that is provided at Cornwall and gave examples such as “mum is content, she is eating well and gaining weight”, “XXXXX and the team do a great job, this is just like a big home, very relaxed”. One of one family member stated she felt very welcome whenever she visits and is often offered the opportunity to stay and have a meal with her mother if she would like to. All staff have up to date first aid certificates as evidenced in staff training records which is sighted and verified during interviews with two of two registered nurses, the manager, administrator and two of two caregivers. Registered nurses attend training offered by the local district health board. Two of two registered nurses practising certificates are sighted. Medication and insulin competencies are required for care staff who administer medication and insulin and these are sighted. Caregivers provide most of the direct provision of care and they have either completed or are currently undergoing training as part of the Aged Care Education Programme (ACE); records sighted. The in-service education programme (sighted) contains the required education for the staff to meet contractual requirements. The visiting podiatrist provides a service to the residents and their annual practising certificate (APC) is sighted. The cook has qualifications in food safety training (NZQA 167 and 168) sighted. GP and nurse practitioners APCs are sighted. The registered nurse is responsible for planning, reviewing and overseeing all aspects of the resident’s care. A verbal handover, which includes a printed recent update of each resident, occurs at the beginning of each shift to ensure all staff is familiar with the resident needs. The handover sheet covers all shifts for the next 24 hours. If there are any concerns from the previous 24 hours this is documented in the handover sheet. Staff are allocated residents to look after each shift and the allocation lasts for two weeks to ensure continuity of care. Health professionals delivering the daily care to residents write in the progress notes at the end of each shift. Resident’s notes are integrated and demonstrate input from a variety of health professionals and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in two of two residents' files, where specialist input is required. Staff and resident turnover is low, supporting continuity of care. Re-assessment, review and evaluation of residents and their needs is ongoing by a RN and occurs as needs change or every six months. Evaluation of the care plan, including consultation with the resident, the GP, family/whanau and or advocate is undertaken to determine the resident's degree of progress towards the desired goals and is used to initiate change where progress differs from that expected. Short term care plans are used for any short term problems. Evidence of this is sighted in a review of three of three files and verified in interviews with three of three residents, three of three families, one of one registered nurse, two of two caregivers, one of one GP and one of one nurse practitioner. Tracer methodology example: A rest home resident XXXXXX *This information has been deleted as it is specific to the health care of a resident.*The 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):**  *(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.

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

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

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

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

#### Standard 1.3.5: 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:** |
| The previous corrective action against criterion 1.3.5.2 of this standard has been addressed. The care plans sighted in three of three files reviewed, documents the plan of care identified by initial, on-going individual assessments, and identifies appropriate, resident guided interventions to enable the resident to meet their need, goal and desired outcome. Care plans are developed in consultation with the resident and/or family/whanau, as evidenced by interview with three of three residents, three of three family / whanau, one of one RN and two of two caregivers.Residents have one set of clinical notes in which all providers involved with the residents care use to document. Evidence of care is sighted as documented by caregivers, registered nurses, activities officer, GP, allied health and specialist care providers. Progress notes, activities notes, medical and allied health professionals’ notations are clearly written, informative and relevant to the care providers.Any change needed, is either written or verbally passed on to those concerned and if implemented is documented in progress notes, handover sheet and the resident's care plan. Care plans sighted are evaluated six monthly or more frequent as the resident's condition dictates. Short term care plans document the existence of short term problems that need intervention as sighted in three of three files reviewed. The ARC requirements are met.  |

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| New residents to Cornwall rest home are made to feel welcome and are orientated to the facility as confirmed with interviews of three of three residents and three of three family/whanau members and one of one RN. The three of three care plans sighted document the desired goals to ensure delivered care and/or interventions are detailed and consistent with services required to residents' assessed needs, desired outcomes and current best practice standards. A short term problem instigated a request by the GP to record a resident’s blood pressure twice daily over a specified time frame. This is sighted as being attended to as requested.Interviews with family/whanau members expressed satisfaction with the care, the respect shown to them and the quality of the food that they or their relative receives.The residents’ are reviewed twice weekly by the GP and nurse practitioner. This is confirmed through interviews with one of one GP and one of one nurse practitioner whom both highly commend the care offered by the Cornwell staff. The DHB clinical nurse specialist and hospice nurses are available for advice, consultation and review. There is evidence of referrals to specialist services and specialists noted in consumer's files as sighted in two of three files reviewed where specialist input is required. Podiatry services are provided by a visiting podiatrist if required. The staff education records sighted for 2013-2014 demonstrate that staff receive appropriate training. Training records evidence education that includes resident’s rights, infection control, medication, cultural safety, sexuality and intimacy, wound care, elder abuse and neglect and management of challenging behaviour. The RNs participate in the training sessions offered by the DHB. Staff are observed to be respectful and deliver care in accordance with current accepted good practice on the days of the audit. The facility has access to up-to-date information on current accepted good practice, clinical care protocols and referenced procedures.The ARC requirements are met. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| On admission, residents are assessed to ascertain their needs and appropriate activity requirements. The activities assessments and plans’ include the resident’s preferences, social history, and past and present interests. The activities plans sighted match the skills, likes, dislikes and interests evidenced in the activity assessment data. The planned monthly activities programme offered is based on resident need and requirements.Activities reflect ordinary patterns of life and include normal community activities (eg, bus outings, visiting entertainers, visits to the local returned services association club, senior citizens clubs, church services and home visits). Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate.Activities are overseen by an activities person who attends all the diversional therapy interest group meetings in the area. She organises activities and outings for the residents every afternoon Monday – Friday. On the day of audit a van outing to the lake had been organised. In the morning the residents read the paper with the facility manager and do the crossword. On a Wednesday morning a local GP who is now retired meets with the residents, reads the paper and discusses any topical issues.Individual activity assessments are updated or reviewed at least three monthly with a monthly summary of the resident’s response to the activities and participation recorded. The goals are developed with the resident and their family, where appropriate.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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Evaluation of resident care at Cornwall rest home is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may contact the GP or nurse practitioner if required. Family/whanau are kept informed of changes. Formal care plan evaluations are conducted at least six monthly or as needs change, by the RN, with the resident and family / whanau if requested. Evaluation is undertaken to measure the degree of achievement or response of each resident related to their goals six monthly. Where progress is different from expected, the service responds by initiating changes to the service delivery plan. When a resident is not responding to the services or interventions, changes are initiated to the care plan. This is evidenced in three of three file reviews, three of three resident, three of three family and one of one RN interview. A short term care plan is initiated for issues such as infections, wound care, changes in mobility and the resident’s general condition. Short term care plans are reviewed, by the RN, daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.The ARC requirements are met.  |

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

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

|  |
| --- |
| **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 1.3.8.3 (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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous corrective action in relation to criterion 1.3.12.1 has been addressed. Residents receive their medicines in a safe and timely manner that complies with legislation and safe practice guidelines. Medicines are dispensed and delivered by the pharmacy in the Douglas Pharmaceuticals Medico Pak delivery system. All medicines are prescribed by the GP. Each resident has an individual medicines profile that includes a photograph and any documented allergies, medicine prescription form, an individually dispensed Medico Pak for their medicines and medicine signing sheets. The received medicines are checked by the RN for accuracy when new sachets or medicines are delivered and this process is observed and records sighted. Any medicines no longer required are returned to the pharmacy.  The safety of residents, visitors, staff and contactors is maintained through appropriate storage and access to medicines. There is locked secure trolley to store medicines in use. When the trolley is not in use it is stored in a locked office. Stock medications are kept in a locked office. Controlled drugs are stored in a separate locked safe, in a locked drawer, in the locked office. Controlled drugs, when dispensed are checked by two nurses, one of whom is medication competent. The controlled drug register evidences weekly checks with six monthly stock take and reconciliation recorded. The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range Interview and observation of the RN undertaking medicine administration on the day of audit verified awareness of the role and responsibilities related to all aspects of medicine management and the regulations concerning administration of controlled drugs. Contents of the medicine pack are observed as checked against the medicine order.Medicine charts reviewed have each medicine signed for when dispensed (or the reason why the medicine was not given) recorded on the signing sheet.There is a specimen signature register maintained for all staff who administers medicine. The medicine charts reviewed have allergies and sensitivities recorded in a prominent position and a recent updated photograph of the resident for identification. Each medicine request is signed individually by the GP or nurse practitioner and records the date of the order, medicine, strength, dose, time, route, frequency and duration. 10 of 10 medicine charts are sighted and evidence this. Medicine reviews by the GP or nurse practitioner is recorded on the medicine chart at least three monthly.Medication errors are reported to the RN, recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. No medication errors have occurred since the last audit, as verified by the sighted accident and incident collation report and interview with the RN and manager.Medication competencies for all staff members who are involved in the provision of medication to residents are current and documentation is sighted. Approved healthcare workers are certified as competent in Medication Administration (documentation sighted), under the direction and delegation of an RN. Staff attended the most recent medication management training session in April 2013. Medication competency was assessed in July 2013. A review of personnel files and training records (see also 1.2.7) confirmed that all staff responsible for medication management have a current competency assessment. The RN (who is a nurse educator at WDHB) monitors these to ensure all staff who administer medications have current competencies. Two residents self-administer non-blister packed medication (Gastro Soothe and Losec). The RN or prescriber assesses physical and mental capacity of the resident to do so. This is reviewed every three months if there is a change in capacity, health status or evidence suggests non-adherence to the prescribed regime. Residents wishing to self-medicate have a signed agreement regarding the resident’s responsibility to safety. Medication chart references the resident self-administers. Staff checks with resident each shift that they have taken their medication. Locked storage is provided that is only accessible to the resident and authorised staff. The documentation to support this is sighted. If standing orders are used. The written authorisation (sighted), signed by the residents GP and nurse practitioner, identifies the directions and clear indications for each medicines use. The standing order specifies the medicines that may be administered under the standing order, the treatment and condition to which the order applies, the recommended dose range, the number of doses the standing order allows, the contraindications for use, the method of administration and the documentation required. The standing order authorisation is reviewed yearly. 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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

##### **Criterion 1.3.12.6 (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):**  *(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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The menu (sighted) is reviewed by the dietitian and was last reviewed in August 2012. The nutritional requirements are based on the Ministry of Health (MoH) food and nutritional guidelines for older people and the facility has a planned menu. The facility has access to a dietician through the WDHB and there is a process for referral. There are policies and procedures relating to food and nutrition services that are reviewed at least two yearly and there is evidence (sighted) that this is last reviewed in September 2013. The cook has appropriate training (NZQA 167 and 168) and evidence of this is sighted. There is evidence to support sufficient food is ordered and prepared to meet the resident’s recommended nutritional requirements. Between meal snacks are available and evidence of this is observed. Interviews with residents and their families confirm satisfaction with meals and service. There is sufficient staff on duty in the dining room at meal times to ensure there is appropriate assistance available. The dining room is clean, warm, light and airy to enhance the eating experience. All food is ordered by the cook weekly. Fruit and vegetables are ordered every two to three days, depending on need and availability. Meat, fish and dried goods are ordered as required. When food is delivered it is checked for ‘use by date’ and damage, then stored in well organised and appropriately temperature controlled storage. Fridge, freezer, dishwasher and cooked meat temperatures are monitored daily. This is evidenced when reviewing temperature records with the cook which demonstrated them to be within accepted parameters. There are separate freezers for meat, bread products and frozen vegetables. Any leftovers are covered and labelled with the date/time/contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days. Separate chopping boards and utensils are used when preparing raw foods that require cooking. A cleaning regime for the kitchen is sighted and evidenced to be complied with. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Dietary profiles, sighted are retained in the kitchen.The ARC requirements are met.  |

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **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:** |
| The Building warrant of fitness for Cornwall is current, and expires on 30 November 2014. There have been no alterations or building work since the last on site audit. |

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

All buildings, plant, and equipment comply with legislation.

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

# 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:** |
| Policy sighted states the use of enablers as “voluntary use of equipment by a resident that limits normal freedom of movement with the intention of promoting independence, comfort of safety”.No residents at Cornwell use enablers at the time of audit. The ARC requirements are met. |

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

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

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

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

#### 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:** |
| In line with the facility's infection control policy and procedures, monthly surveillance of infections, by the registered nurse is occurring. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month at Cornwall rest home, are recorded on an infection report form and graphed. Incidents of infections are sighted and are low. These are collated each month and analysed to identify any significant trends or possible causative factors. Currently there is a QA meeting every month and a staff meeting every month where the incidents of infection are presented. Any actions required are implemented. Outcomes are presented to staff at daily handover and staff meetings and any necessary corrective actions discussed. Findings are presented at board meetings, with any necessary board requirements discussed and actioned.Surveillance records for 2013 are reviewed and show one urine infection, three wound infections (June, July and November) and 11 chest infections (from May to October).  |

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

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

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

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

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

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