Summerset Care Limited - Summerset at the Course

Current Status: 28 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

Summerset at the Course provides rest home and hospital level care for up to 60 residents. On the day of audit there are 19 rest home residents (including 10 in serviced apartments) and 30 hospital residents. There is an experienced aged care village manager who has been in the role for four years. She is supported by a nurse manager who is currently orientating to the role and has previously been in the role of clinical leader and RN for the last six years. There are job descriptions for both positions that include responsibilities and accountabilities. Summerset's regional manager, clinical educator and clinical and quality manager are available to support the team at Summerset at the Course.

The service has addressed all five shortfalls identified in their previous certification audit around the hazard register, post falls observations, clinical documentation, individual activity care plans, freezer monitoring and cleaning schedules in the kitchen.

This audit has identified improvements required around the documentation of risks associated with the use of enablers and indications for use of ‘as required’ medications.

Audit Summary as at 28 January 2014

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 28 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 28 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 28 January 2014

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

Safe and Appropriate Environment as at 28 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 28 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 28 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 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Summerset Care Limited
Certificate name:	Summerset Care Limited - Summerset at the Course

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit
Premises audited:	Summerset - Summerset at the Course
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	**Start date:** 28 January 2014 **End date:** 29 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:	49

Audit Team

Lead Auditor	XXXXX	**Hours on site**	13	**Hours off site**	5
Other Auditors		**Total hours on site**		**Total hours off site**	
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	2

Sample Totals

Total audit hours on site	13	Total audit hours off site	7	Total audit hours	20

Number of residents interviewed	2	Number of staff interviewed	10	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	40	Number of relatives interviewed	6
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Monday, 24 February 2014

Executive Summary of Audit

General Overview
Summerset at the Course provides rest home and hospital level care for up to 60 residents. On the day of audit there are 19 rest home residents (including 10 in serviced apartments) and 30 hospital residents. There is an experienced aged care village manager who has been in the role for four years. She is supported by a nurse manager who is currently orientating to the role and has previously been in the role of clinical leader and RN for the last six years. There are job descriptions for both positions that include responsibilities and accountabilities. Summerset's regional manager, clinical educator and clinical and quality manager are available to support the team at Summerset at the Course. The service has addressed all five shortfalls identified in their previous certification audit around the hazard register, post falls observations, clinical documentation, individual activity care plans, freezer monitoring and cleaning schedules in the kitchen. This audit has identified improvements required around the documentation of risks associated with the use of enablers and indications for use of 'as required' medications.

Outcome 1.1: Consumer Rights
There is an open disclosure policy, which describes ways that information is provided to residents, and families/representatives at entry to the service continually and as required. Family are involved care planning and receive and provide on-going feedback. The privacy and dignity of residents is respected. Residents and family meetings are held and resident/relative surveys are completed annually. Regular contact is maintained with family including if an incident/ accident or a change in residents health status occurs. A complaints register is maintained. The complaints register reviewed included two documented verbal concerns) and one written complaint. There is evidence of follow up and resolution.

Outcome 1.2: Organisational Management
There is a quality and risk management programme and process that has been established and implemented. There is an internal audit schedule, which is completed. Quality data gathered includes the use of comprehensive forms and online data entry. Data is collated monthly and trends identified. Corrective actions plans, implementation of plans and resolution occur when trends are identified. There is discussion of quality data and any identified improvements evidenced at all staff meetings including quality improvement meetings, health and safety/infection control, registered nurse and caregiver meetings. There is an implemented planned annual in-service programme for all staff that includes monthly training. Staff training records are maintained. Annual performance appraisals are completed. Staff and residents reported that staffing levels are sufficient.

Outcome 1.3: Continuum of Service Delivery
Assessments, care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are completed on admission and reviewed at least six monthly. Care plans demonstrate service integration and are individualised. Short term care plans are used for acute changes in health status. There is a multidisciplinary approach in the evaluation of care plans six monthly. An improvement is required around the documentation of risks identified with the use of enablers. The diversional therapist provides an activities programme for the residents that is varied, interesting and involves the families and community. Storage, delivery and administration of medications meet medicine management requirements. Staff administering medication have completed medication

competency assessments. There are improvements required around the prescribing of 'as required' medication to include an indication for use.
Meals are prepared on site by a contracted catering company Medirest. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for.

Outcome 1.4: Safe and Appropriate Environment

The facility has a current Warrant of Fitness. There is an approved evacuation scheme. Six monthly fire drills are conducted. Staff have received training in emergency management.

Outcome 2: Restraint Minimisation and Safe Practice

There is a documented definition of restraint and enablers. The process of assessment and evaluation of enabler use is included in the policy. There are currently five residents using an enabler. There are no residents with restraint.

Outcome 3: Infection Prevention and Control

The infection control policy includes a surveillance policy. Infections are included on a monthly resident infection and surveillance report and a monthly report is completed by the infection control officer, which is presented at the monthly quality improvement meetings. The infection control programme is linked with the quality management programme and is discussed at the various facility meetings. The infection control data entered on line is reviewed by the Summersets Clinical Quality Manager monthly and any areas for improvement are highlighted and follow up corrective action is discussed with the nurse manager and infection control officer at the relevant facility.
Systems in place are appropriate to the size and complexity of the facility.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	15	0	2	0	0	0
Criteria	0	38	0	2	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)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	The identified risks of enabler use is not documented in the long term care plan for two residents with enablers.	Ensure risks associated with the use of enablers is documented in the long term care plan.	60
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Six medication charts did not have indications for use for prn medications charted (codeine phosphate, metoclopramide tablets and injections, oxycodone and clonazepam).	Ensure prn medication have indications for use charted by the GP.	60

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA
Evidence: Full information is provided at entry to residents and family/representatives. Access to interpreter services is identified in the community and through the Maori Health services. Families are involved in the initial care planning and in on-going care. An information to family newsletter is sent out six monthly that includes an update/review of their relatives care plan and any other significant information. Regular contact is maintained with families as evidenced by a registered nurse to family contact form in the progress notes. ARC D11.3 The information pack is available in large print and advised that this can be read to residents. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. This includes 'charging in ORAs-no other benefit for services'. D16.4b: Interviews with six relatives (four hospital, two rest home) all confirmed that they are always informed when their family members health status changes and for any accidents/incidents that occur. A sample of incidents forms (six) reviewed from December 2013 identified that all six forms evidenced that family were contacted. There is a resident advocate that attends the resident meetings and information is fed back to the management team. Families are also invited to attend resident meetings. The village manager and nurse manager office is based within the care centre. Both are readily available to residents and families and promote open communication

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

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

Attainment and Risk: FA
Evidence:

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 service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. The village manager is responsible for ensuring complaints are addressed within the required timeframe and maintains contact with the complainant throughout the complaints process. The nurse manager is involved in any complaints regarding care. Verbal concerns are processed in the same way as written complaints. A complaints register is maintained. There are three concerns (two relative, one resident) registered. Each concern has been acknowledged by letter and investigated to the satisfaction of the complainant. All concerns were resolved within three days. Age concern advocate was invited to attend a meeting regarding one concern. Opportunities for improvement are identified and implemented. Complaints, outcomes and improvements are discussed at Management and staff meetings (minutes sighted). Staff attended open disclosure/complaints offered in March and July 2013. Interviews with six relatives and two residents confirmed that they were well informed around the complaint process and stated management are approachable if they have any concerns. D13.3h. A complaints procedure is provided to residents within the information pack at entry.

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

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

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: Summersets overall vision is "older New Zealanders should have access to a quality lifestyle in a safe, secure and enjoyable environment at an affordable cost.". The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset at the Course has a site specific business plan and goals that is developed in consultation with the village manager, nurse manager and regional operations manager (ROM). The plan is separated into sections and focus areas, including; a) financial goals, b) property, c) clinical quality, d) health and safety, e) infection control, f) human resources, g) sales and marketing, and h) risk. The Summerset at the Course quality plan is reviewed regulary throughout the year. There is a full evaluation at the end of the year. The 2013 evaluation is sighted. The village manager (non-clinical) has been in the current role at Summerset for four years and has attended at least eight hours of leadership professional development relevant to the role. The village manager is supported by a nurse manager. The nurse manager has been employed at the faciity as a registered nurse (four years) and a team leader (18 months) prior to being appointed as the the nurse manager. On the day of audit the nurse manager was being orientated to the role by the company clinical education manager. The clinical leader vacancy is currently being processed by the company human resource department. Village managers and nurse managers attend annual organisational forums and regional forums over two days. The nurse manager attends clinical education, forums/provider meetings at the local DHB. There is a regional operations manager who is available to support the facility and staff. Advised by the village manager that the regional operations manager is available to be contacted by telephone or email as required. Policies and procedures are developed at an organisational level with input from staff and external specialist expertise where required. D17.3di (rest home) & D17.4b (hospital), the nurse manager has maintained clinical education as a clinical leader and is currently receiving orientation to the nurse manager role. An education and training plan is in place.

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: Summerset at the Course has an established quality and risk management system. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings and a set agenda item for the quality meeting, Health and safety, infection control, RN and caregiver meetings. The service has a variety of monthly meetings to ensure organisational performance is monitored. Key components of the quality management system link to the monthly quality improvement meetings. The nurse manager, health and safety committee and infection control officer all provide a clinical report to the village manager at the quality meetings. The quality improvement meeting is chaired by the village manager and attended by the property manager, nurse manager, diversional therapist, infection control officer, health and safety representative, restraints co-ordinator, housekeeping/ laundry representatives as required. Set agenda items include; resident care issues, clinical updates, audit results and corrective action plans, improvement projects, health and safety, infection control, complaints/compliments, policies and reviews, staff training, supplier performance, maintenance and any other business. The village manager reports to the regional operations manager and Summersets support office provide a coordinated process between service level and organisation. The introduction of staff “munch” meetings is a successful quality initiative that has seen an increase in staff attendance. The meetings are open to all staff. Meetings are held weekly and light lunch is provided. Staff interviewed state they are kept updated on all aspects of the service, accidents/incidents, concerns/complaints, audits and outcomes. There is an internal audit plan. Audits include a summary, any issues arising and corrective actions when required. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the nurse manager that break down the data collected across the rest home and hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed. An ACC

workplace safer management practices (WSMP) audit is completed annually. The service has secondary level of WSMP.
Summersets Clinical and Quality Manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes.
Summerset has a data tool "Sway- The Summerset Way" that was launched in 2012 by the organisation. Sway is integrated and accommodates the data entered.
Results from the care survey are in the process of being collated. The resident and family satisfaction survey (sighted) and discussion with the resident advocate (sighted) identified a need for weekend activities. There is now a weekend activity person. Resident satisfaction is being monitored through resident meetings and verbal feedback.

Policies and procedures are developed at organisational level. The policies and procedures and associated implementation systems provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.
The facility has a master copy on computer of all policies & procedures with a master also of clinical forms filed in folders alphabetically. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly by Summersets Clinical and Quality Manager. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies. Discussion regarding policy development/review occurs at staff meetings. Release of updated or new policy o curs across the organisation (sighted). The release of a policy coincides with an audit and staff education. These is a policy/procedure sign off sheet to use within the facilities for staff to sign as having noted/read the new/reviewed policy. Four caregivers, one enrolled nurse and two registered nurses interviewed are able to describe the process regarding the review or release of new policies and procedures. Staff state they are aware of the results of internal audits, health and safety and infection control data, trends and corrective actions.
D19.3: There is a comprehensive H&S and risk management programme in place. The nurse manager is the health and safety officer.
There is a current hazard register formatted on a controlled document with that is dated. This is an improvement from the previous audit.
D19.2g Falls prevention strategies are in place that include the analysis of falls incidents, falls assessment for ambulant residents and the identification of interventions on a case by case basis to minimise future falls. Strategies and equipment available to minimise falls risk are, floor sensor mats, nurse call bells and mobility aids and hi-low beds.

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: Incidents/accidents are investigated and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality improvement meetings, health and safety meetings and staff "munch" meetings that include actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The December 2013 monthly incident/accident analysis form observed completed, documents date, name of resident, place, time, site/area of facility, type of incident/accident, any injury, contributing factors and if a resident, staff or visitor. This data is entered into the intranet system, graphed and benchmarked. Categories monitored are skin tears, bruising, falls with injury and falls without injury and medication errors. Pressure areas and behavioural concerns are reported on accident/incident forms. There were six incidents/accidents sampled for the month of December 2013. All accident/ incident forms are complete and evidence the family have been notified. There is RN follow up and review of incident. Neurological observations have been completed following a resident fall with a knock to the head. This is an improvement from the previous audit. Six incidents were traced back to the care plans and progress notes of respective residents. The care plans and progress notes reflected the incident and documented registered nurse assessment any emergency treatment given, preventative measures to be implemented (where appropriate) and contact with family/whanau. Two registered nurses and the nurse manager interviewed advised that RN's are in regular contact with family and this is evidenced by entries on the RN to family contact form in the resident file. Monthly incident/accident analysis occurs with subsequent annual summary and analysis. There is a policy and procedure for the reporting of sentinel events. A flow chart is available for staff information and action required. The village manager (interviewed) is aware of the reporting requirements for sentinel events.

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: The recruitment and staff selection process requires that relevant checks, including police checks (as appropriate) are completed to validate the individual's application, qualifications and experience. A copy of registered nurse practising certificates are kept on file. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (nurse manager, one registered nurses, two caregiver/diversional therapists (DT), one cleaner). The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Files evidence completed orientations and checklist. There are annual performance appraisals in the staff files sampled. The newly appointed nurse manager is currently being orientated to the role. The village manager and nurse manager attend N.Z. aged care association providers meetings and forums as offered. An agreement is made with all new employees to commence Careerforce training. The facility nurse manager and DT are on-site assessors. The company education manager and DT team leader are company assessors. Discussion with the clinical education manager confirm there is a comprehensive in-service training programme in place that is generated by the company however the programme can be amended to meet the facility requirements. The programme covers relevant aspects of care and support and aligns with the internal audit programme. Careerforce training is provided weekly. Practical training such as skills based and pictorials meets the learning style of the students. Power point training has also been set up on the intranet. The goal for staff training is to achieve a 90% attendance rate. Weekly targeted training (condensed versions) will be completed for staff who have not attended scheduled training. Individual training records are maintained on line. The annual training programme exceeds eight hours annually. The registered nurses attend external training including seminars and sessions provided by Summerset add the local DHB. Education provided in 2013 includes: code of rights, Manual handling, medication, nutrition and hydration, continence, pain and symptom management, restraint minimisation, challenging behaviour, privacy and dignity, infection control. All staff are trained in first aid. Training occurs at least monthly and

records include date, session topic, and names of attendees. The RN's attend two external training sessions a year of their choice, however this year the RN's will attend interRAI training at the DHB.
17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); Medication, Insulin administration, use of Oxygen, and Syringe driver.

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:
Sufficient staff are rostered on duty to manage the care requirements of the rest home and hospital residents at the care centre and care apartments. The village manager works 40 hours per week Monday to Friday and is available on call for non-clinical issues. The nurse manager works 40 hours per week Monday to Friday and is available on call for any emergency issues or clinical support. The service provides 24 hour RN cover. Care staff work either four days on, two days off or two days on

and four days off. A senior is allocated to the care apartments on morning and afternoon shifts and is covered by a senior caregiver in the rest home at night. A staff availability list ensures that staff sickness and vacant shifts are filled. Caregivers interviewed confirmed that staff are replaced especially in the weekends. Determining Staffing Levels and Skills Mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. This defines staffing ratios to residents.

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

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

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 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Attainment and Risk: FA
Evidence:
Care staff write up progress notes every morning shift and for any resident significant events. The RN writes entries into the medical continuation notes. All entries in the progress notes and medical continuation notes are dated with designations. This is an improvement from the previous audit.

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

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: D.16.2, 3, 4: The five resident files sampled (three hospital and two rest home) identified that the RNs complete an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. All five files sampled identified that the long term support plan is developed within three weeks. All five long term care plans sampled are signed and dated by the RN. Families confirmed on interview they are invited to attend care plan reviews and GP visits. The diversional therapist completes an activity assessment and care plan in consultation with the resident/family/whanau as appropriate. D16.5e: Four of five resident files sampled identified that the GP had seen the resident within two working days. One resident in the care apartment had been assessed in hospital prior to discharge requiring rest home level of care. It was noted in all resident files sampled that the GP had examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced in files of residents with more complex conditions or acute changes to health status. All five resident files sampled identified integration of allied health professionals and a team approach. There is a verbal handover at the beginning of each shift to the caregivers to ensure staff are kept informed of resident's health status and any significant events. Handover also includes any policy reviews/updates and brief in service as applicable. The RNs and care staff meet weekly to discuss any clinical matters. Five caregivers interviewed state the communication system is good and they relevant information at handover to deliver safe and timely cares for the residents. There is adequate equipment to carry out the cares as instructed in the care plans including (but not limited to); hoists, slidy sheets, transferring belts, walking frames, sensor mats, pager system for call bells, chair scales, wheelchairs, electric beds, gloves and aprons. The physiotherapist is contracted for two hours a week. A podiatrist visits six weekly. The residents have access to on-site hairdresser and beautician services. Tracer methodology: hospital level resident XXXXXX *This information has been deleted as it is specific to the health care of a resident.* Tracer methodology: rest home resident

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: The RN assesses all residents on admission and completes individualised care plans. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. Six family members state their relative's needs are being met. A range of assessment tools are completed on admission and reviewed at least three monthly as applicable and include (but not limited to); continence, falls assessment and safe manual handling, pressure area, pain assessment, wound, nutritional, cultural needs assessment and activity initial assessment. D18.3 Dressing supplies are available and adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment is sighted. There are adequate supplies of incontinent products in all areas. Wound assessment and on-going treatment/management plans are in place for five minor wounds, chronic leg ulcers (one resident) and five skin tears. There is one sacral pressure area. There are adequate pressure area resources in place and on-going monitoring and interventions such as two hourly turning. All wounds have an initial wound assessment and on-going wound assessments with each dressing change. Dressing types and evaluations are documented on the on-going wound assessment treatment form. There are short term care plans are in place for skin tears. The chronic wound is linked to the long term care plan. Evaluations occur at the required frequency, dated and signed by the RN. The DHB wound nurse is accessed as required. Staff attended pressure area care education November 2013. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day and night use. Specialist continence advice is available as needed and the nurse manager could describe the referral process. The product representative is available for advice, resources, and education. Staff attended continence management education in September 2013. All falls are reported on the resident accident/incident form. Falls risk assessments and safe manual handling assessments are completed on admission and reviewed at

least three monthly or earlier if required. There is evidence of physiotherapist referrals and involvement in resident assessments, post hospital assessments and rehabilitation as required. Staff attended falls management in September 2013 and incidents/accidents in October 2013.
Resident's weight is recorded on admission and monitored monthly. Chair scales are available and have been calibrated. MUST nutritional screening is completed for residents identified with weight loss. Interventions include more frequent weighing, food and fluid monitoring, dietary supplements, GP notification. A referral is sent to the DHB dietitian as required. The speech language therapist is involved for swallowing difficulties.

Pain assessments are completed in five of five residents files sampled. Pain assessments are reviewed at least three monthly and reviewed as part of the GP three monthly review. Pain management (pharmalogical and non-pharmalogical) is included in the long term care plans. The effectiveness of pain relief is documented in the progress notes. Staff attended pain management education August 2013.
Altered behaviours are monitored. The GP is notified and any medical causes excluded. There is evidence of one resident reviewed by the psychogeriatrician and a medication review carried out. The service has access to the mental health nurse practitioner who liaises closely with the mental health team. The nurse practitioner is available for advice and education. Staff attended challenging behaviour and restraint education May 2013.
Enabler use for two residents is identified in the long term care plan. There is an improvement required around the documentation of identified risks with enabler use.

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

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

Attainment and Risk: PA Low
Evidence: Residents who choose to use an enabler sign an enabler consent form. The restraints officer completes an enabler assessment form that includes risks identified with the use of the enabler. The use of enabler is documented in the long term care plan.
Finding: The identified risks of enabler use is not documented in the long term care plan for two residents with enablers.
Corrective Action: Ensure risks associated with the use of enablers is documented in the long term care plan.
Timeframe (days): 60 *(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: There is currently a relieving qualified Diversional Therapist (DT) and senior caregiver employed to implement the activity programme. There is one activity person on each day from 9.30am to 4pm and seven days a week. The rest home and hospital programme is integrated. There is a separate programme for the care apartments and village. Rest home residents are welcome to join in the village activities and there are combined functions for the whole complex such as barbeques and market

days.
The programme is planned a month in advance and follows a set plan that is also flexible to meet the preferences of the group and individual needs. A resident advocate and family are invited to attend resident meetings. Residents have an opportunity to feedback on the programme. The programme is displayed in large print. Volunteers are involved in newspaper reading and one on one activities. Combined rest home and hospital activities and entertainment take place in the large main lounge. There are other areas in the facility where small group or individual activities (one on one) can take place. Resident choice to participate in activities is respected. Group activities include news, bingo, movies, baking, crosswords, it and be fit exercises, walks, memory games, bowls, crafts, balloon games, gardening and flower arranging. Community visitors to the home include kindergarten and play centre children, RSA singers, church visitors and singing groups, school groups, musical entertainers and visitors with dogs on Sundays. Residents if able attend their own churches on Sundays and RSA functions. There are twice weekly drives in the wheelchair hoist van. A designated driver and the activities person accompany residents on outings. The activities persons have a current first aid certificate.
Activity assessments are completed with resident/family/whanau involvement. Each resident has an individual activity plan. This is an improvement from the previous audit. The resident/family are involved in the care plan reviews, which occur at the same time as the review of the clinical care plan.

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: All residents are required to have an individual activity plan.
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: There is documented evidence of written multidisciplinary reviews held three monthly involving the resident/family/whanau, RN, nurse manager, restraints officer, diversional therapist, primary caregiver, manual handling officer, medical review and where applicable allied health input. The RNs amend the long term support plan to reflect on-going changes as part of the review process. Allied health professionals involved in the residents care are linked to the support care plan review such as, dietitian, physiotherapist, podiatrist and diabetic educator. Allied health notes are maintained in the residents file. All five resident files sampled documented discussions with family/whanau regarding changes to health, incidents, infections, MDT meetings (care plan review), and GP visits. There are short term care plans in place for short term needs such as painful wrist, ear infection, skin tears, UTI, chest infection and bruise. Short term care plans have been evaluated regularly and either resolved or if

an on-going problem included in the long term care plan.

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: PA Low
Evidence: The service uses individualised robotic packs for regular and prn medications. The medications are delivered monthly and signed off on the pharmacy delivery form. The night shift RN completes a medication reconciliation. PRN medications are checked monthly for expiry dates. There is one main medication room for the rest home and hospital. All pharmaceuticals are stored safely within the locked treatment room. RN's and senior caregivers who administer medications have annual competency assessments and attend annual medication education (June 2013). RNs have attended syringe driver education. The hospital has liverpool care pathway medications in stock. There are current standing orders dated March 2013. There are no self-medicating residents. Controlled drugs are checked weekly. A pharmacy audit is completed six monthly. The pharmacy returns box is kept in the locked treatment room. All eye drops are dated on opening. The medication fridge temperature is recorded weekly. Emergency oxygen is available and checked weekly. There is an approved container for the disposal of sharps. Medication signing sheets are all correct with no gaps. There is a prn medication administration sheet that details date, time, medication given, strength, route, indication, effectiveness, comments and signature. There are blood sugar monitoring and insulin administration sheets, digoxin pulse charts and anticoagulant monitoring forms and dosages. Duplicate name labels are used. All prescribed medications on the 10 medication charts are signed by the GP. There is an improvement required around the indications for use of prn medications. All medication charts had photo identification and allergies documented. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident medications three monthly.

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

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

Attainment and Risk: PA Low
Evidence: All prescribed medications on the 10 medication charts are signed by the GP. Four of ten medication charts had indications for use of prn medications.
Finding: Six medication charts did not have indications for use for prn medications charted (codeine phosphate, metoclopramide tablets and injections, oxycodone and clonazepam).
Corrective Action: Ensure prn medication have indications for use charted by the GP.
Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)
Service providers responsible for medicine management are competent to perform the function for each stage they manage.

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: Food services at Summerset is contracted to Medirest. The company dietitian (interviewed) is based at the facility and develops the menus and recipes for all of the Summerset facilities. A list of alternative choices are available. The menus are changed every eight weeks and reviewed each time to ensure nutritional requirements for the elderly are met. Site changes to menus can be made to meet the resident's preferences. All foods are cooked on site. End point cooking temperatures are checked and recorded daily. There is a qualified chef on daily from 8.30am to 5pm. There is a morning kitchen assistant and afternoon kitchen assistant. Care staff prepare and serve breakfast. The kitchen has a servery to the main dining room. Menus are written up daily on the menu board. Meals are plated, covered and transported by trolley to the smaller dining area. Meals are transported in the bain marie to the care apartments. The chef receives dietary requirements forms for new residents that describes special diets, likes and dislikes. The chef (interviewed) is notified of any dietary changes and is aware of any residents with weight loss. Nutritional drinks and high calorie diets are offered. Normal, pureed and vegetarian meals are provided. Alternative choices are offered as required. A communication book is used between food services staff. The kitchen is well equipped with combioven, two freezers and chillers. There is daily recording of the chiller and freezers. This is an improvement from the previous audit. The dishwasher is checked monthly by the chemical supplier. The dry foods in the pantry are all off the floor, sealed and labelled with expiry dates. Foods are labelled in the fridges and chiller. Kitchen cleaning schedules are in place and signed as cleaning duties are completed (sighted). This is an improvement from the previous audit. D19.2. Staff have attended training in safe food handling. A fresher is scheduled for October 2014. Chemical safety training was completed November 2013.

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

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

Attainment and Risk: FA
Evidence:

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

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

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

Attainment and Risk: FA
Evidence:
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 facility has a current building warrant of fitness that expires on 2 October 2014. There is an approved evacuation scheme. Fire drills are conducted six monthly. Staff have received education in fire safety and emergency management.

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: There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134. The policy identifies that restraint is used as a last resort. There is a checklist of alternative approaches and/or interventions that could be used to minimise restraint usage. There are currently no restraints. There are five enablers in use, which are four bedsides and one lap belt. There is an enabler register. The relative/resident (as appropriate), GP and restraints officer sign an enabler agreement form. There is an enabler assessment carried out and this is reviewed by the restraints officer and multidisciplinary team as part of the six monthly review. The use of enablers are identified in the resident care plan. Risks for the use of an enabler is identified on the assessment form. Risks are not included in the care plan of two residents with enablers (link 1.3.6.1). There is evidence of a restraint being reassessed to an enabler in consultation with resident/family and staff. Restraint is discussed at the quality meeting, RN and staff meetings. Challenging behaviour and restraint education has been attended in May 2013. Restraint is included in the caregiver orientation and a self-learning package completed.

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: The infection control policy includes a surveillance policy. The surveillance policy includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. The infection control committee includes the infection control co-ordinator/RN, five caregivers, DT, kitchen, laundry and kitchen representatives. The company infection control programme is scheduled for review at the next quality meeting. All infections are documented on short term care plans. Infections under surveillance are eye, UTI, respiratory, wound, multi-resistant organisms, skin and soft tissue, diarrhoeal and other. A monthly data base of infections are summarised and graphed. The infection control officer provides information to staff including trends and correction actions required. Staff interviewed state infection control information is available and discussed at staff meetings. An infection control report is provided at the quality meeting. The infection control co-ordinator has access to Bugs control, medlab and GP advice as required and has attended an infection control and prevention conference. The infection control data entered on line is reviewed by the Summerset Clinical Quality Manager monthly and any areas for improvement are highlighted and follow up corrective action is discussed with the nurse manager and infection control officer at the relevant facility. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits are completed and corrective actions are signed off (sighted). Staff receive infection control education during orientation and as per the education schedule. There have been no outbreaks.

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

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

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

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

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

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