Devonport Palms Retirement Limited

Current Status: 26 February 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

Devonport Palms is certified to provide rest home level of care for up to 30 residents. On the day of the audit, there were 30 residents living at the facility, which included two residents who were at the facility for respite care. The facility manager is the owner of the facility; he is supported by a clinical manager who is a registered nurse.

The facility has addressed six of the seven previous identified shortfalls since the last audit around investigating incidents and accidents, documenting an initial care plan as part of the admission process, ensuring care plans are individualised, ensuring the medication cupboard is kept locked at all times, and ensuring there is a staff member on duty at all times with a current first aid certificate.

Further improvements continue to be required around pain assessment and management.

This audit identified improvement required around developing corrective action plans, annual performance appraisals, behaviour management plans, medication competencies, and medication standing orders.

Audit Summary as at 26 February 2014

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

Consumer Rights as at 26 February 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 26 February 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.		Some standards applicable to this service partially attained and of low risk.

Continuum of Service Delivery as at 26 February 2014

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

Safe and Appropriate Environment as at 26 February 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 26 February 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 26 February 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:	Devonport Palms Retirement Limited
Certificate name:	Devonport Palms Retirement Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit			
Premises audited:	Devonport Palms Retirement Complex			
Services audited:	Rest home care (excluding dementia care)			
Dates of audit:	**Start date:**	26 February 2014	**End date:**	26 February 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:	30

Audit Team

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

Sample Totals

Total audit hours on site	16	Total audit hours off site	10	Total audit hours	26

Number of residents interviewed	4	Number of staff interviewed	4	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)	17	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	

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 Thursday, 27 March 2014

Executive Summary of Audit

General Overview
Devonport Palms is certified to provide rest home level of care for up to 30 residents. On the day of the audit, there were 30 residents living at the facility, which included two residents who were at the facility for respite care. The facility manager is the owner of the facility, he is supported by a clinical manager who is a registered nurse. The facility has addressed six of the seven previous identified shortfalls since the last audit around investigating incidents and accidents, documenting an initial care plan as part of the admission process, ensuring care plans are individualised, ensuring the medication cupboard is kept locked at all times, and ensuring there is a staff member on duty at all times with a current first aid certificate. Further improvements continue to be required around pain assessment/management. This audit identified improvement required around developing corrective action plans, annual performance appraisals, behaviour management plans, medication competencies, and medication standing orders.

Outcome 1.1: Consumer Rights
Evidence of open disclosure to families is documented appropriately. Families interviews confirm that they are kept informed regarding the residents' health status and of any adverse events. The rights of the resident and their family to make a complaint is understood, respected and upheld by the service.

Outcome 1.2: Organisational Management
Services are coordinated, and are appropriate to the needs of the residents. This ensures the provision of timely, appropriate and safe services to the residents. Quality and risk management processes are documented and maintained. Adverse, unplanned and untoward events are recorded in a systematic fashion. This includes an investigation by a registered nurse for any clinical events. This is an improvement from the previous audit. Residents receive appropriate services from suitably qualified staff. Human resources processes are managed in accordance with good employment practice, meeting legislative requirements. Education and training programmes are in place for staff relating to the care of the elderly. The registered nurses received specialised training to ensure good practice. There are two identified shortfalls, corrective action plans for identified improvements in the kitchen and laundry have proven ineffective over a period of time and annual performance appraisals for staff are overdue.

Outcome 1.3: Continuum of Service Delivery
Initial assessments and care plans are developed by the RN and reviewed at least six monthly. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate. Previous findings relating to care plan interventions have been addressed. Risk assessment tools and monitoring forms are available to assess the level of risk and support required for residents; however, the previous finding around pain assessments remains. There is an improvement required around pain monitoring and behaviour management. Residents and family members interviewed state that they are kept involved and informed about the resident's care. The medication management system includes medication policy and procedures that follows recognised standards. Staff responsible for medication

administration attends annual education. Resident medications are reviewed by the residents' general practitioner at least three monthly. Storage of medications has improved since the previous audit. This audit identified improvements around review of standing orders and medication competencies.
A range of activities is available and residents provide feedback on the programme. Community links are maintained. Regular outings and entertainment is enjoyed by residents interviewed.
There are food policies/procedures for food services and menu planning appropriate for this type of service. Food safety in-service is completed by staff, dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs.

Outcome 1.4: Safe and Appropriate Environment

A current Building Warrant of Fitness is in place. There is a minimum of one person available at all times who holds a current first aid certificate. This is an improvement from the previous audit.
The service has a current building warrant of fitness, which expires 21 January 2015. All building and equipment meets legislative requirements.

Outcome 2: Restraint Minimisation and Safe Practice

The use of restraint is actively minimised. Restraint is regarded as the last resort. A restraint/enabler assessment process is in place. There are no restraints or enablers being used. Staff are required to attend restraint minimisation and safe practice education.

Outcome 3: Infection Prevention and Control

The infection control surveillance policy is based on definitions of infection in long-term care facilities. Surveillance data including types of infections, trends, corrective actions and quality initiatives are reported to relevant committees and staff meetings. Internal infection control audits including hand hygiene are completed. The service infection control surveillance stats are benchmarked against rest homes of similar bed size within the Cavell group.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	14	0	4	1	0	0
Criteria	0	38	0	4	2	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	31
Criteria	0	0	0	0	0	0	0	57

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	There are repeated trends (for five months or longer) relating to the cleanliness of the kitchen, residents entering the kitchen and cleanliness in the laundry that are documented as on-going issues in the internal auditing programme. The facility manager reports he is aware of issues and has recently had an external reviewer from the Cavell Group audit the kitchen and laundry services. Further investigations are underway by the facility manager to ensure issues identified in the kitchen and laundry is dealt with in an effective manner.	Ensure corrective actions that are implemented are effective to eliminate on-going trends relating to the cleanliness of the kitchen, residents entering the kitchen and the cleanliness of the laundry.	90
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 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.	PA Low	There is a lack of evidence in three of three staff files of up-to-date annual performance appraisals. The facility manager/owner reports he is aware that there are some outstanding performance appraisals and he is currently working on completing them.	Ensure staff have annual performance appraisals, which identify any training needs and opportunities.	90
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	There are no pain assessments on admission for two residents who identify pain on initial assessment. ii) Pain assessment for one resident on controlled pain relief has not been reviewed since January 2012.	Ensure formal pain assessments are completed on admission for residents who identify with pain. Ensure pain assessments are reviewed at least six monthly.	30
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			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	(i)There are three reports in the progress notes of breakthrough pain for one resident. There is no monitoring of the effectiveness of pain relief. (ii) There are no behaviour charts or behaviour management plan for two residents with altered behaviour.	Ensure pain is monitored and the effectiveness of pain relief, (ii) Ensure behaviour monitoring an behaviour management plans are completed where required	90
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low			
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	Standing orders for five out of 10 medication charts sampled have not been reviewed annually.	Standing orders are to be reviewed annually by the GP.	90
HDS(C)S.2008	Criterion 1.3.12.3	Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Low	Medication competent staff are required to complete a medication competency.	Ensure staff administering medications complete an annual medication competency.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA
Evidence: The open disclosure policy describes the steps to take in the event a resident has suffered any unintended harm while receiving care. Six of six residents' incidents and accidents reviewed reflect evidence on the incident and accident form and on the family contact sheet of families being kept informed. Two of two family interviews confirm that they are kept informed. The interpreters' policy includes contact details of interpreter services. Family and staff are used in the first instance.

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 policy aligns with the requirements set forth by the Health and Disability Commissioner. Residents/family can lodge formal or informal, verbal and written complaints. Complaints forms are available to residents and families. Complaints can also be lodged through the residents' meetings that are held four to five times a year. Interviews with four of four residents (three rest home level and one respite) and two family members of residents at the rest home level of care confirm that they are familiar with the complaints procedure. They all report that concerns and complaints are addressed before they become formal complaints. The facility manager/owner reports the service has had no formal complaints lodged since it opened. In the event a complaint is received, a complaints' log will be incorporated into the corrective action form (CAF) register. Interviews with two of two caregivers confirm that any issues or concerns that are raised are dealt with in a timely manner.

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: The service is owned by a member of the Cavell Group. The Cavell Group is comprised of six independent aged care providers who share policies and provide collegial support while maintaining their independent businesses. A mission and philosophy of care are defined for the service. At the time of the audit, there were 30 rest home level residents living in this 30-bed facility that is dedicated to the rest home level care. Two respite care residents were living temporarily at the facility. The quality and risk management system is regularly reviewed by the facility manager/owner and clinical manager (link 1.2.3.8).

The facility manager has a background in management and keeps up to date with the aged care sector through regular attendance at Cavell Group meetings and New Zealand Aged Care Provider forums. His professional development, relating to the management of the service exceeds eight hours per year. He is supported by a clinical manager/registered nurse and other Cavell group members

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: PA Low

Evidence:

The service uses the Cavell Group mission and quality policy, which includes a quality plan and a risk management plan. The facility manager/owner reports he is responsible for providing oversight of the quality and risk management programmes. He is supported by a clinical manager/registered nurse. There is evidence of annual reviews of the quality and risk management plans.

Interviews with the facility manager/owner, the clinical manager and two caregivers confirm that quality data such as internal audits, adverse events, and infections are discussed at the staff meetings. This was also evidenced in the staff meeting minutes.

Cavell Group policies and procedures are in place for service. Policies are subject to a minimum of two-yearly reviews. A document control process is implemented with hard copies and electronic versions of policies and procedures available to staff. Policies are reviewed throughout the year on a rolling calendar. Polices are circulated to all Cavell Group directors and managers for consultation. Updated or obsolete documents are deleted from the web master copy and paper copies are removed and archived.

Key components of the quality system include monitoring all adverse events (eg, falls, skin tears, verbal and/or physical abuse, wandering, medication errors), infections or complaints (if any). Meeting minutes include a standard agenda for discussions relating to complaints/compliments, incidents and accidents, health and safety, infection control, audit reports, training and other issues as identified. The facility manager benchmarks data with other similar Cavell Group facilities including occupancy, incidents and accidents, infections, admissions, discharges.

The service's internal audit programme monitors the laundry services, sluice rooms, environmental cleanliness of the kitchen and residents' rooms, the meal service, kitchen and resident tap water temperatures, hazard controls, medication, and preventative maintenance. Audit results are discussed at the staff and health and safety meetings. Corrective actions are implemented in most instances where opportunities for improvements are identified although there are repeated trends (for five months or longer) relating to the cleanliness of the kitchen, residents entering the kitchen and cleanliness in the laundry that are documented as on-going issues. Corrective actions have not been implemented to effectively deal with these issues.

A number of quality initiatives have been implemented by the service. Examples include implementation of the Bay of Plenty District Health Board's initiative Working Well, a health promotion initiative for staff; pharmacy assessments of all residents' file every two-three months; and a resident choir that meets weekly with 90% or the residents involved with the choir. The implementation of the InterRAI tool is underway.

Risk to the service are identified, analysed and evaluated in the risk management plan. The controls that are in place in the hazard register are monitored every month. Hazard identification reports are completed to identify new hazards.

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: PA Low
Evidence: Corrective actions are implemented in most instances where opportunities for improvements are identified although there are repeated trends (for five months or longer) relating to the cleanliness of the kitchen, residents entering the kitchen and cleanliness in the laundry that are documented as on-going issues. Corrective actions have not been implemented to effectively deal with these issues.
Finding: There are repeated trends (for five months or longer) relating to the cleanliness of the kitchen, residents entering the kitchen and cleanliness in the laundry that are documented as on-going issues in the internal auditing programme. The facility manager reports he is aware of issues and has recently had an external reviewer from the Cavell Group audit the kitchen and laundry services. Further investigations are underway by the facility manager to ensure issues identified in the kitchen and laundry is dealt with in an effective manner.
Corrective Action: Ensure corrective actions that are implemented are effective to eliminate on-going trends relating to the cleanliness of the kitchen, residents entering the kitchen and the cleanliness of the laundry.
Timeframe (days): 90 *(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: The facility manager/owner is aware of situations in which he would need to report and notify statutory authorities. The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process. Staff receives education at orientation on the incident and accident reporting process. Staff interviewed understand the adverse event reporting process and their obligation to documenting all untoward events. Six incident/accident reports were selected for review, which included three falls with no injury and three falls with minor injuries. All six-incident reports had a corresponding note in the progress notes to inform staff of the incident. Of the six incidents, there was evidence of an investigation and sign-off by the registered nurse Investigations included appropriate follow-up care (neurology observations for one resident with a suspected head injury, and the development of a short-term wound care plan for two residents with skin tears). This is an improvement from the previous audit (criterion 1.4.3). There was evidence of open disclosure for each recorded event (reference 1.1.9). A monthly summary sheet of adverse events includes the incident type, and number, hazards identified, the risk category, actions taken and the date completed.

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: PA Low
Evidence: The clinical manager is a registered nurse who holds a current annual practising certificate. A central file contains copies of practicing certificates for the pharmacists, dietitian and the doctors involved with residents at the service. The staff employment processes include recruitment, selection, orientation and performance appraisals. Five staff files were randomly selected for review (one registered nurse, one cook, three caregivers). All five staff files contain orientation documentation, reference checks, and signed job descriptions. The orientation programme provides new staff with relevant information for safe work practice. This includes the service's values, history and structure, key processes, health and safety, fire safety, code of rights, quality systems, and education and training. Orientation is specific to the role and responsibilities of the position. A staff education and training programme is in place. Mandatory topics covered include manual handling, infection control, medication, fire drills, advocacy and code of rights, informed consent and complaints, elder abuse, incontinence, diabetes, arthritis management, stroke management, end of life care and challenging behaviours. Staff competencies are completed for a wide variety of skills and to determine the staffs' knowledge (link 1.3.12.3). The clinical manager attends external training as available through the Bay of Plenty District Health Board and local hospice. Her annual training programme exceeds eight hours annually. There is one identified shortfall. Annual performance appraisals for staff are overdue (evidenced in three of three staff files where staff had been employed for longer than one year).

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: PA Low
Evidence: A staff education and training programme is in place. Mandatory topics covered include manual handling, infection control, medication, fire drills, advocacy and code of rights, informed consent and complaints, elder abuse, incontinence, diabetes, arthritis management, stroke management, end of life care and challenging behaviours. Staff competencies are completed for a wide variety of skills and to determine the staffs' knowledge (link 1.3.12.3). The clinical manager attends external training as available through the Bay of Plenty District Health Board and local hospice. Her annual training programme exceeds eight hours annually. There is one identified shortfall. Annual performance appraisals for staff are overdue (evidenced in three of three staff files where staff had been employed for longer than one year).
Finding: There is a lack of evidence in three of three staff files of up-to-date annual performance appraisals. The facility manager/owner reports he is aware that there are some outstanding performance appraisals and he is currently working on completing them.
Corrective Action: Ensure staff have annual performance appraisals, which identify any training needs and opportunities.
Timeframe (days): 90 *(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: A documented rationale for staffing the service is in place. Staffing rosters reflect the availability of staff to match the needs of the residents. The clinical manager reports she is available Monday – Friday from 5:30am to 6:00pm Monday – Friday. A casual registered nurse is available to cover when the clinical manager is on leave. A registered nurse is on-call 24 hours a day, seven days a week. There are three caregivers staffed for the am shift, two caregivers for the pm shift and one caregiver during the night shift, seven days a week. Caregivers do not perform any laundry or cleaning duties. An additional caregiver assists from 4pm – 6pm in the dining room (Monday – Friday) and from 8am – 11am every second weekend. Family, residents and staff confirm there are sufficient numbers of staff on duty at all times.

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: D16.2, 3, 4: The five files reviewed identified that an initial assessment and care plan is completed by the registered nurse (RN) within 24 hours of admission. Four of five files reviewed identify that the long term nursing care plan is completed within three weeks. One respite care file sampled identified a short-term care plan implemented on admission. This is an improvement from the previous audit. There is documented evidence that the care plans are reviewed by a RN and amended when current health changes. Four of four long-term nursing care plans evidenced evaluations completed at least six monthly. A range of assessment tools available for use on admission (where applicable) include (but not limited to); a) coombe falls risk and resident manual handling profile b) pressure area risk assessment, c) continence assessment d) pain assessment. D16.5e: Four or four permanent resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and to be reviewed three monthly. There are regular in-house GP clinics. There is close liaison with the mental health team who monitor residents with mental health concerns. The smaller home environment is known to be therapeutic for these residents. The GP completes a three monthly medication review. Staff could describe a verbal handover at the end of each duty that covers any new resident changes to health or mobility, medication changes, care plan updates

maintains and other relevant information that assists staff in the provision of continuity of service delivery. Handover is observed on the day of audit. Progress notes are written daily and for any significant events that occur.
Resident files reviewed identified integration of allied health and a team approach.
Five resident rest home files reviewed

Tracer methodology:
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 1.3.4: Assessment (HDS(C)S.2008:1.3.4)
Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Attainment and Risk: PA Moderate
Evidence: There are no pain assessments on admission for two residents who identify pain on initial assessment. This remains an improvement from the previous audit.

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)
The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Attainment and Risk: PA Moderate
Evidence: There are a range of assessment tools available on admission including (but not limited to); a) falls assessment, b) continence assessment, c) pressure area assessment and d) pain assessment. This remains an improvement from the previous audit.
Finding: There are no pain assessments on admission for two residents who identify pain on initial assessment. ii) Pain assessment for one resident on controlled pain relief has not been reviewed since January 2012.
Corrective Action: Ensure formal pain assessments are completed on admission for residents who identify with pain. Ensure pain assessments are reviewed at least six monthly.

Timeframe (days): 30 *(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: Four long-term resident files sampled evidenced individualised plans of care and support in all areas of care including spiritual and cultural needs. One respite care resident file sampled has a short-term care plan in place with support and interventions in place to meet the resident goals. This is an improvement from the previous audit.

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: PA Low
Evidence: Care plans are completed by the RN/Clinical manager. The clinical manager has completed InterRAI training and commencing the change to InterRAI assessments. Care delivery and any changes in residents condition is reported to the registered nurses who initiates a nursing review, referral or GP consultation as required. Family/whanau are informed of their relatives change in health status, accidents/incidents and GP visits as evidenced on the family contact notes in the five resident files

sampled.
AD18.3 and 4 Dressing supplies are available and treatment rooms are well stocked for use. Wound care assessment and management plans and dressing plans are used for wound management documentation. Currently there are no skin tears, wounds or pressure areas.
There are adequate continence products available and individual allocations of products according to continence assessments.
Monitoring charts such as fluid charts, blood pressure monitoring and weight monitoring are evidenced in use.
There are three reports in the progress notes of breakthrough pain for one resident. There is no monitoring of the effectiveness of pain relief. There are no behaviour charts or behaviour management plan for two residents with altered behaviour. These are areas requiring improvement.

Resident falls are reported directly to the RN on a written accident/incident form. Falls risk assessments are reviewed. Appropriate interventions are documented. Short-term care plans for falls with injury are completed and neurological observations are sighted in the resident file with falls. All resident related monitoring equipment is available and have current calibrations and functional checks.

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 Moderate
Evidence: A range of assessment tools available for use on admission (where applicable) include (but not limited to); a) Coombe falls risk and resident manual handling profile b) pressure area risk assessment, c) continence assessment d) pain assessment e) behaviour recording chart. Care delivery and any changes in residents condition is reported to the registered nurses who initiate a nursing review, referral or GP consultation as required.
Finding: (i)There are three reports in the progress notes of breakthrough pain for one resident. There is no monitoring of the effectiveness of pain relief. (ii) There are no behaviour charts or behaviour management plan for two residents with altered behaviour.
Corrective Action: Ensure pain is monitored and the effectiveness of pain relief, (ii) Ensure behaviour monitoring an behaviour management plans are completed where required
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: FA
Evidence: The service employs a diversional therapist (DT) for 25 hours per week Monday to Friday. The DT attends the local DT support group meetings and education as offered. The DT has a current first aid certificate and has completed dementia training. The activities programme is planned one month in advance and includes (but not limited

to); quizzes, yahtzee, exercises, memory lane, carpet bowls, news and discussion, walking groups and men's group. Exercises groups and other activities are alternated between the upstairs and downstairs lounges. There is regular entertainment provided and a choir group has been formed. Community links are maintained with visits to the RSA, Lyceum club, "recycled teenagers" club, shopping and café visits in the community, visiting blind foundation, Parkinson's and Alzheimer's support groups. There are fortnightly church services alternating between Anglican and the interdenominational churches. Taxi and rental buses are used for the regular outings with a designated driver. Preparation is underway for a train trip this week to Waihi. There are regular resident meetings with the opportunity for residents to feedback on the programme and offer suggestions for outings and entertainment.
The DT completes a resident assessment and profile on admission and an activity plan within three to four weeks of admission. The activity plan is reviewed six monthly at the same time as the care plan. Attendance sheets are maintained.

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:
There is a GP examination and medication review at least three monthly. Long-term care plans are reviewed and evaluated by the RN six monthly or earlier when there are changes to health care status. Changes to the long-term care plan are made as required and at the six monthly review if necessary. Short-term care plans evidenced regular evaluations. On-going problems are added to the long-term care plan. The multidisciplinary team include the clinical manager, care staff, GP, resident/family/whanau (as appropriate) and allied health professionals involved in the care of the resident such as the mental health case manager. D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated. ARC: D16.3c: All initial care plans were evaluated by the RN within three weeks of admission

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:
Medication policies align with accepted guidelines. Medications are stored in a locked cupboard. The controlled drugs (blister packed) are also stored in a locked cupboard. The cupboard is locked on the day of audit. This is an improvement since the previous audit. The four weekly blister pack medications are checked on

delivery by the RN and team leader. The blister pack is signed by the pharmacists and the RN after checking.
Returns are kept in safe storage until collected by the pharmacy. All controlled drugs are checked weekly by an RN and another medication competent person and recorded in the controlled drug register. RN's and caregivers who complete a medication competency assessment are responsible for the administration of medications. Medication competent staff are required to complete a medication competency annually. Annual education is provided by the medico representative or the supplying pharmacist. There is a medication administration specimen signing list. There are no self-medicating residents. Standing orders are available for each resident and kept with the resident medication charts. Standing orders for five out of 10 medication charts sampled require an annual review. Medications requiring refrigeration are stored in sealer containers in the kitchen fridge, which is monitored daily.
Medication charts meet legislative prescribing requirements. All 10 medication charts sampled have photo identification and any allergies/adverse reactions noted. All prn medications administered have the date and time of administration on the signing sheet. PRN medications have the indication for use on the medication chart. The pharmacy generate new medication charts for any changes made by the GP. The GP signs the new medication chart within a week.

D16.5.e.i.2; 16 f 16 medication charts reviewed identified that the GP had seen the resident three monthly and the medication chart was reviewed and signed.

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: The pharmacy generate new medication charts for any changes made by the GP. The GP signs the new medication chart within a week. Standing orders are available for each resident and kept with the resident medication charts. Standing orders for five out of 10 medication charts sampled require an annual review
Finding: Standing orders for five out of 10 medication charts sampled have not been reviewed annually.
Corrective Action: Standing orders are to be reviewed annually by the GP.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

Attainment and Risk: PA Low
Evidence: RN's and caregivers who complete a medication competency assessment are responsible for the administration of medications. Annual education is provided by the medico representative or the supplying pharmacist. There is a medication administration specimen signing list.
Finding: Medication competent staff are required to complete a medication competency.

Corrective Action: Ensure staff administering medications complete an annual medication competency.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.12.5 (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 service employ a qualified chef (level four city guild certificate) and a relieving cook. The chef works from 0630am to 6.30pm (split shifts) preparing and cooking the three meals and baking for the morning and afternoon teas. There's a four weekly seasonal menu that has been reviewed by the dietitian. There is a resident likes/dislikes list in the kitchen. Alternative choices are offered. Normal and soft diets are provided. The kitchen is notified of any changes to resident's dietary requirements. Currently there are no weight loss concerns. The chef is observed wearing correct personal protective wear. Daily fridge and freezer temperature monitoring is recorded. Hot food and cooked meat temperatures are checked daily and recorded weekly. All foods in the fridge is labelled and meat is stored at the bottom of the fridge. The pantry is clean and tidy with all foods off the floor. Dry goods are in sealed labelled and dated containers. Cleaning schedules are in place. Chemicals are stored safely in the kitchen. Feedback on the service is through the resident meetings, food satisfaction surveys and daily contact with the chef during the serving of meals and presence in the dining room. Four residents interviewed stated they are happy with the meals and enjoyed the home baking. They are offered alternative choices when required for dislikes.

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: A current Building Warrant of Fitness is in place (expiry 21 May 2015). The facility is a modern purpose built home with 30 spacious single bedrooms and large communal areas readily accessible to the residents. The building has a current building warrant of fitness that expires 21 January 2015. There is an approved fire evacuation scheme. The external areas are well maintained and safely accessible for

residents.

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.)*

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)
The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

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

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)
Consumers are provided with safe and accessible external areas that meet their needs.

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 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

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

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

Attainment and Risk: FA
Evidence: There is a minimum of one staff available at all times who holds a current first aid and CPR certificate. The facility manager/owner reports all staff hold current certificates with the exception of two employees who are scheduled to attend training on 28 February 2014. This is an improvement from the previous audit (criterion 1.4.7.2).

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): *(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: The restraint minimisation policy describes the processes for the voluntary use of enablers and how these are differentiated from restraint use. The clinical manager is the restraint coordinator. There are no restraints or enablers in use. Restraint minimisation and managing challenging behaviours is included in the education and training programme and includes staff completing a competency questionnaire.

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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinators (clinical manager and RN) use the information obtained through surveillance to plan and determine infection control activities, resources and education needs within the facility. Resident infections are reported on resident infection assessment forms and collated monthly. The service uses the definition of infections for surveillance in long-term care facilities. Surveillance includes respiratory tract, urinary, skin and soft tissue/cellulitis, eye infections, diarrhoeal and MRSA. Short-term care plans are implemented for all infections. The pharmacy provides a monthly report of antibiotic use. A monthly analysis of types of infections, trends, corrective actions and quality initiatives is reported to the quarterly Cavell group management meetings and at the infection control monthly meetings and regular staff meetings. Infection control data is benchmarked against rest homes of similar bed size within the Cavell group. There are internal audits including hand hygiene audits.

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.)*