

Kohatu Resthome Limited

Current Status: 12 March 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

Kohatu Rest Home provides care for up to 24 residents who require rest home care. There were 22 residents on the day of this audit. The facility is operated by Kohatu Rest Home Limited.

This unannounced surveillance audit has been undertaken to establish compliance with the required Health and Disability Services Standards and the District Health Board contract. Residents and family interviewed report that the care provided is very good.

The area requiring improvement from the last audit has been addressed. Improvements to the service have been identified during this audit relating to corrective actions plans, the currency of staff performance appraisals, the currency of medication competencies, the currency of the building warrant of fitness, maintenance of resident documentation, the safe management of medication, the menu approved by the dietitian not being adhered to, and not all infections being included in infection control surveillance data.

Audit Summary as at 12 March 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 12 March 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 12 March 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 medium or high risk and/or unattained and of low risk.
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Continuum of Service Delivery as at 12 March 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 12 March 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Restraint Minimisation and Safe Practice as at 12 March 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 12 March 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of low risk</p>
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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:	Kohatu Resthome Limited		
Certificate name:	Kohatu Resthome Limited		
Designated Auditing Agency:	Health Audit (NZ) Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Kohatu Resthome		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	Start date: 12 March 2014	End date: 12 March 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:			22

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	4
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2.5

Sample Totals

Total audit hours on site	16	Total audit hours off site	10.5	Total audit hours	26.5
Number of residents interviewed	3	Number of staff interviewed	6	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	4	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	16	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

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

I confirm that:

a)	I am a delegated authority of Health Audit (NZ) Limited	Yes
b)	Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health Audit (NZ) 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 Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Monday, 24 March 2014

Executive Summary of Audit

General Overview

Kohatu Rest Home provides care for up to 24 residents who require rest home care, and there were 22 residents on the day of this audit. The facility is operated by Kohatu Rest Home Limited. This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract. Residents and family interviewed report that the care provided is very good.

The area requiring improvement from the last audit has been addressed. Improvement to service has been identified during this audit relating to corrective actions plans, the currency of staff performance appraisals, the currency of medication competencies, the currency of the building warrant of fitness, maintenance of resident documentation, the safe management of medication, the menu approved by the dietitian not being adhered to, and not all infections being included in infection control surveillance data.

Outcome 1.1: Consumer Rights

The service provides an environment conducive to effective communication. Residents and family members interviewed report that services are provided in a manner that respects residents' rights and facilitates informed choice. They report that they are very happy with the service provided and that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and any significant change in a resident's condition. The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is displayed along with complaint forms.

The manager/registered nurse is responsible for management of complaints. There have been 11 internal complaints since the last audit and no complaints investigated by external agencies.

Outcome 1.2: Organisational Management

Kohatu Rest Home Limited is the governing body and is responsible for the service provided at Kohatu Rest Home. Planning documents reviewed include a business plan, and a quality manual as well as a philosophy of care and core values for the service. Systems are in place for monitoring the service provided at Kohatu Rest Home, including regular monthly reporting to the owners. Reporting also occurs via staff meetings.

The facility is managed by a suitably qualified and experienced manager who is also an experienced registered nurse with extensive aged care experience and has been in this position since November 2008.

There is evidence that quality improvement data is being collected, collated and analysed to identify trends and this information is reported to the owners and to staff via combined monthly Quality/Infection Control/Health and Safety/Staff meetings, and via the manager's monthly reports to the owners. There is an internal audit programme in place. There is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. There is an area requiring improving relating to corrective action plans not being developed and implemented when a deficit is identified following the completion of internal audits.

The adverse event reporting system provides evidence of a planned and co-ordinated process, with service providers documenting adverse, unplanned or untoward events. Resident files reviewed provide evidence of communication to families following adverse events involving the resident, or any change in the resident's condition. Family members interviewed during this audit confirm this.

There are policies and procedures on human resources management and the validation of current annual practising certificates for the manager/registered nurse (RN), pharmacist, physiotherapist, podiatrist and general practitioners (GPs) is occurring.

The human resource management system provides for the implementation of processes both at the commencement of employment and ongoing in relation to staff education. The manager is responsible for facilitation of the in-service education programme at Kohatu Rest Home and in-service education is provided at least once a month. An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff are supported to complete the Careerforce education programme and 'Care Training on Line'. Review of staff records provides evidence of human resources processes being followed and individual education records are maintained. The area requiring improvement from the last audit under criterion 1.4.7.2 is addressed. There is at least one staff member on each duty who has a current first aid certificate. Improvement is required from this audit relating to not all performance appraisals are current, and not all staff who are responsible for medicine management have current competency assessments.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of one caregiver. The manager/RN is on call after hours. Care staff interviewed report there is adequate staff available and that they are able to get through their work

Outcome 1.3: Continuum of Service Delivery

Time frames for service provision are defined, however evidence of timeframes could not be confirmed and an improvement is required. Care plans and interventions sighted are current and sufficiently detailed to meet the health and wellbeing needs of residents, however an additional improvement is required to ensure plans and interventions are consistently documented and reviews conducted regularly.

Activities are planned to meet the needs of the resident. Individual activity goals are documented and ensure the provision of relevant and appropriate activities. Previous interests, hobbies, culture and ability is considered. Sufficient activities and outings are provided and participation in activities is voluntary.

An appropriate medication management system is in place and medications are monitored by the manager and the GP. An improvement is required to ensure prescribing and storage of medications meets legislative requirements and guidelines and evidence of medication competencies needs to be maintained.

Food and nutritional needs of residents are assessed and the menu is reviewed by a dietitian. Special needs are catered for and monitored. Food preparation and storage meets food safety requirements, however records of any deviation from the menu have not been maintained and an improvement is required.

Outcome 1.4: Safe and Appropriate Environment

Improvement is required relating to the Building Warrant of Fitness for Kohatu Rest Home having expired on the 7 March 2014. An existing small lounge has been divided with an internal wall to create another bedroom. This has not impacted on bed numbers.

Outcome 2: Restraint Minimisation and Safe Practice

There are adequately documented guidelines on the use of restraints and enablers. Alternatives to restraint are in use. There are no restraints or enablers in

use. All staff receive sufficient training on restraint and enabler use.

Outcome 3: Infection Prevention and Control

The infection control programme is clearly documented and is suitable for a rest home setting. The infection surveillance program is appropriate for the facility and the level of care provided, however not all infections have been included in the surveillance programme and an improvement is required. Infection data is analysed for trends and communicated to staff. There have been no infection issues or out breaks since the last audit.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	7	0	5	3	1	0
Criteria	0	26	0	5	4	1	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	34
Criteria	0	0	0	0	0	0	0	65

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			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	Corrective actions plans are not being developed following completion of internal audits when a deficit is identified.	Provide evidence that corrective actions plans are being developed following completion of internal audit when a deficit is identified.	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 Moderate			
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 Moderate	Not all staff have current performance appraisals and not all staff that are responsible for medicine management have current competency assessments.	Provide evidence that all staff have current performance appraisals and all staff that are responsible for medicine management have current competency assessments.	90
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 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.	PA Low	There is insufficient evidence that time frames for service delivery have been maintained. This includes signing of service agreements on entry.	Provide evidence that time frames for service delivery are maintained.	90
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Not all the required interventions are documented. This includes the development of short term care plans and records of required observations in progress notes.	Document short term care plans for all short terms problems or variations to current care. Maintain records of observations.	60
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 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.	PA Low	Current care plan reviews are not sighted in resident records sampled.	Fully implement the review process.	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 Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	The medicine management system does not meet legislative requirements, guidelines or best practice with regard to prescribing and storage.	Provide evidence that the medicine management system meets legislative requirements, guidelines or best practice with regard to prescribing and storage.	7
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 Moderate	Evidence of medication competency has not been maintained.	Provide evidence that all staff administering medication are competent to do so.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.1	Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	Deviations to the menu are sometimes made, however a record of this has not been maintained.	Maintain records of deviations to the menu.	30
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA High			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA High	The BWOFF for Kohatu Rest Home expired on the 7 March 2014.	Provide evidence of a current BWOFF.	7
HDS(IPC)S.2008	Standard 3.5: Surveillance	Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(IPC)S.2008	Criterion 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.	PA Low	Not all infections have been added into the surveillance data.	Include all infections in surveillance data	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:

Open disclosure procedures are in place to ensure service providers maintain open, transparent communication with residents. Residents files reviewed provide evidence of notification to family following changes in the resident's condition. All bedrooms are single and there are appropriate places available for private discussions, if required. Residents are able to identify service providers involved in their care. Three residents and two family interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care. The manager/registered nurse (RN) advises access to interpreter services is available if required via advocacy services. Staff interviewed advise they currently have no residents who require interpreters. ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Attainment and Risk: FA
Evidence: Systems are in place to ensure residents are advised on entry to the facility of the complaint processes. Three residents and two family interviewed demonstrate an understanding of these processes. The service has appropriate systems in place to manage the complaints processes and a register is maintained. The manager/RN advises there have been 11 internal complaints, both verbal and written and no complaint investigations by the Health & Disability Commissioner, Ministry of Health, District Health Board, Police, Accident Compensation Corporation (ACC) or Coroner since the previous surveillance audit. ARC requirements are met.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Systems are established and maintained which define the scope, direction and goals of the facility and monitoring and reporting processes against these. A 'Kohatu Business Plan 2012/2014' is reviewed that includes mission, values statement, vision, purpose, key objectives and key performance indicators.

Organisational performance is formally monitored through monthly reports to the owners. The manager/RN also reports the owners visit at least weekly, and they are updated on all matters concerning the day to day management of Kohatu Rest Home.

The facility is managed by a suitably qualified and experienced manager who is an experienced registered nurse with extensive aged care experience and

has been in this position since November 2008. The Activities co-ordinator / administrator is responsible for the day-to-day management of the facility during the Manager's absence with support from a registered nurse from a GP's practice, if needed.

ARC requirements are met.

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

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

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

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

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

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Attainment and Risk: PA Low

Evidence:

The quality manual and quality and risk management plan is sighted and used to guide the quality programme and includes quality goals and objectives. There is an internal audit programme in place and completed internal audits for 2013 and 2014 are reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A Health and Safety manual is available that includes relevant policies and procedures.

Clinical indicators and quality improvement data is recorded on various registers and forms and are reviewed as part of this audit. There is documented evidence quality improvement data is being collected, collated and analysed including reporting on numbers of various clinical indicators and quality and risk issues to staff via combined monthly quality/infection control/health and safety/staff meetings, and via the manager's monthly reports to the owners. Quality improvement data reviewed, including internal audits, and improvements are required as corrective actions are not being developed following deficits being identified. (See criterion 1.2.3.8). Staff interviewed report they are kept well informed of quality and risk management issues including clinical indicators.

Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. The manager/RN is currently reviewing and developing some processes/systems relating to service delivery, and these are yet to be fully implemented. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies in the staff room, via handover, and meetings.

Not all ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (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:

Combined meetings are held monthly and minutes are reviewed and corrective actions are developed and implemented following these meetings. Internal audits are reviewed for 2013 and 2014 and do not have corrective actions plans developed. This is an area that requires improvement.

Finding:

Corrective actions plans are not being developed following completion of internal audits when a deficit is identified.

Corrective Action:

Provide evidence that corrective actions plans are being developed following completion of internal audit when a deficit is identified.

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: <p>The adverse event reporting system provides evidence of a planned and co-ordinated process. Adverse, unplanned or untoward events are recorded on an accident/incident form, sighted, which are then reviewed by the manager/RN, and who follows up as required. Once the accident/incident form is completed it is entered on to an incident/accident register in the resident's file, and data is collated monthly, sighted. Quality/infection control/health and safety/staff meeting minutes reviewed and demonstrate that quality and risk issues, including reporting on numbers of events is occurring at these meetings e.g. accident/incident/event reporting outcomes, complaints, audit outcomes, infection control, health & safety, and any restraint usage.</p> <p>There is an open disclosure policy. Five resident files reviewed provide evidence of communication with families following adverse events involving the resident, or any change in the resident's condition.</p> <p>Staff confirm during interview that they are made aware of their essential notification responsibilities through: job descriptions and policies and procedures. Policies and procedures comply with essential notification reporting e.g. health and safety, human resources, infection control. ARC requirements are met.</p>

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

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

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

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

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

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

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: PA Moderate
Evidence:
<p>The area requiring improvement from the last audit under criterion 1.4.7.2 is addressed. There is at least one staff member on each duty who has a current first aid certificate.</p> <p>Written policies and procedures in relation to human resource management are available and are reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on staff files (four of four) along with employment agreements, reference checking, completed orientations and competency assessments (as appropriate). Current practising certificates are sighted for the manager/RN, pharmacist, physiotherapist, podiatrist and the GPs that visit the facility.</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided i.e.: the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation's vision, values and philosophy.</p> <p>The human resource management system provides for the implementation of processes both at the commencement of employment and on-going in relation to staff education. Careerforce education is provided and staff are just commencing 'Care Training on Line' and they are supported to complete these education programmes. The education programmes for 2013 and 2014 are reviewed and meet the requirements of the 'Health and Disability Sector</p>

Standards' and the DHB Contract. Review of education records and individual records of education (four of four) are maintained for each staff member, and provide evidence that staff have attended monthly training sessions, and also attend external education including 20 hours of palliative care provided by the local hospice.

An appraisal schedule is in place, however, not all performance appraisals are current, some have not been completed since 2011 and 2012. This is an area requiring improvement. (See criterion 1.2.7.5).

Not all the ARC requirements are met.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Moderate
<p>Evidence:</p> <p>The human resource management system provides for the implementation of processes for on-going staff education. Careerforce education is provided and staff are just commencing 'Care Training on Line' and they are supported to complete these education programmes. The manager/RN is responsible for the education of staff and is also a Career force assessor. The education programmes for 2013 and 2014 are reviewed and meet the requirements of the 'Health and Disability Sector Standards' and the DHB Contract. Review of education records and individual records of education (four of four) are maintained for each staff member, and provides evidence that staff have attended monthly training sessions, and also attend external education including 20 hours of palliative care provided by the local hospice.</p> <p>An appraisal schedule is in place, however, not all performance appraisals are current, and some have not been completed since 2011 and 2012. Not all staff who administer medication have current competency assessment; this includes the manager/RN. (Link criterion 1.3 12 3) These are areas requiring improvement.</p>
<p>Finding:</p> <p>Not all staff have current performance appraisals and not all staff that are responsible for medicine management have current competency assessments.</p>
<p>Corrective Action:</p> <p>Provide evidence that all staff have current performance appraisals and all staff that are responsible for medicine management have current competency assessments.</p>
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 clearly documented staffing rationale is sighted for determining service provider levels and skill mixes in order to provide safe service delivery in place at Kohatu Rest Home that is based on best practice. The roster is reviewed and the minimum amount of staff is provided during the night shift and consists of one care giver. The manager/RN is on call after hours. All care staff interviewed report there is adequate staff available and that they are able to get through their work.

Residents and family members interviewed report there is enough staff on duty to provide them with adequate care. Visual observations during this audit confirm adequate staff cover is provided.

The ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5cj; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: PA Low

Evidence:

Each stage of service provision is completed by a suitably qualified person. Assessments and care plans are developed and reviewed by the manager. Daily interventions and support with activities of daily living are implemented with the help of trained carers and (visiting) allied health providers. For example the District Nurse.

Timeframes for service delivery are defined, however there is some difficulty evidencing that time frames are consistently met and an improvement is required. Files sampled have the required initial nursing assessment/short term plan and a medical assessment is conducted by the GP within forty eight hours. Care plans are developed and implemented to meet the identified needs and goals of the resident and are required to be reviewed every six months (refer to criterion 1.3.8.3).

Continuity of care is maintained. Residents' files sampled evidence multidisciplinary involvement and daily handovers ensure day to day continuity. A visiting allied health provider (district nurse) is interviewed during the audit and confirms that staff effectively implement suggested interventions. This is also confirmed by the General Practitioner (GP) interviewed.

District Health Board contract requirements are not fully met. For example time frames for service delivery have not been met.

Resident file reviewed using 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: PA Low

Evidence:

The manager is in the process of implementing new documentation (assessments and some care planning/review documents), however this is yet to be fully implemented and has resulted in a number of documents not being dated therefore timeframes for service delivery cannot be confirmed (in some places). Signed resident Admission Agreements are not sighted in two out of five resident records sampled.

Finding:

There is insufficient evidence that time frames for service delivery have been maintained. This includes signing of service agreements on entry.

Corrective Action:

Provide evidence that time frames for service delivery are maintained.

Timeframe (days): 90 (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 Moderate

Evidence:

The care plan includes focus, related factors, expected outcomes, interventions and disciplines. Care plan domains include activities of daily living (ADL) function (hygiene, grooming, nutrition and fluid intake), psychosocial (impaired decision making), sexuality and intimacy, pressure areas, pain management, falls risk, cultural needs and spiritual needs. The Nurse Manager is in the process of developing care plans using the interRAI process.

Interventions are time framed. Interventions sighted reflect assessed needs and goals of the resident and are consistent with best practice in working with older adults. The GP and visiting District Nurse interviewed are satisfied that clinical interventions are implemented in a timely and competent manner.

Short term care plans are utilised, however these are not always developed when required and progress notes do not consistently provide sufficient detail of observations/interventions.

The District Health Board contract requirements have been met.

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

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

Attainment and Risk: PA Moderate

Evidence:

Short term care plans are not consistently documented where required. Evidence of the required interventions (where required) are not consistently documented in progress notes. For example there are no records of observations prior to, or following, diagnosis of a urinary tract infection.

Finding:

Not all the required interventions are documented. This includes the development of short term care plans and records of required observations in progress notes.

Corrective Action:

Document short term care plans for all short terms problems or variations to current care. Maintain records of observations.

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:

The activity programme is developed and coordinated by a senior carer who is allocated 25 hours per week. The carer is on site five days per week.

The current activities plan is sighted and provides a sufficient range of planned activities to develop and maintain strengths and interests. Regular exercises and outings are provided for those able to partake. Past activity plans sighted also confirm that a wide range of group activities have been consistently provided. Participation in activities is monitored and reviewed. All residents' files sampled have the required activities care plans and recreation progress notes reports.

Resident meetings and general feedback is provided regarding satisfaction with activities. Resident and family interviewed are satisfied with the range and variety of activities provided and confirm that attendance is voluntary.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Care plan reviews are the responsibility of the Nurse Manager and are required to be completed every six month. The review includes input from the staff, the resident and family. The Nurse Manager has recently implemented a new process (and record) for the completion of reviews, however this is yet to be fully implemented and an improvement is required.

There is recorded evidence of additional input from professional, specialist or multi-disciplinary sources, if this is required and three monthly GP reviews are evident in resident files sampled.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: PA Low

Evidence:

The Nurse Manager has recently implemented a new process (and record) for the completion of reviews, however this is yet to be fully implemented and an improvement is required. All care plans sighted were current.

Finding:

Current care plan reviews are not sighted in resident records sampled.

Corrective Action:

Fully implement the review process.

Timeframe (days): 90 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

Attainment and Risk: PA Moderate

Evidence:

There are adequately documented policies and procedures for all stages of medicine management. Policies reflect legislative requirements. The pre-packed medication system (Blister packs) is implemented and all medicines are prescribed by the GP. Medication charts sampled are legible, signed and dated appropriately, however three out of 10 charts sampled required an improvement in order to meet the relevant legislation and guidelines. Standing orders also require updating to include the 2012 Guidelines. Three monthly GP medication reviews are evident.

Blister packed medications are stored in the medication trolley (in the hall way) and non-blister packed medication, including controlled drugs, are stored in a secure cabinet in the Nurse Manager’s office. Two areas of improvement are required regarding the storage of medicines. This includes the storage of a controlled drug and maintaining evidence of medication fridge temperature monitoring.

The controlled drug box is double locked and the controlled drug register is maintained. The controlled drug register is sampled and identifies a discrepancy on the day of the audit which requires an improvement. The required pharmacy checks of controlled drugs are being conducted six monthly.

Medications are administered by the registered nurses and carers. Competencies for medication management are assessed by the Nurse Manager and a staff competency register is documented. The mid-day medication round is observed and the practice of administration was inconsistent with best practice and an improvement is required. The Nurse Manager is also required to complete a medication competency.

Administration records are well maintained and there are no residents who self-medicate.

The District Health Board contract requirements are met. Policies comply with the Medicines Act 1981 and residents’ medication is reviewed on entry to the facility. This includes a medication reconciliation (sighted in GP records).

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 Moderate
Evidence: <p>Three of 10 medication files sampled do not meet legislative requirements with regard to prescribing. One prescription did not include the GP's signature (Ventolin and flixotide), one did not have allergies recorded and one did not have the prescriber's signature on a discontinued medication order.</p> <p>Not all controlled drugs have been stored securely. Three bottles of codeine phosphate are sighted in the medication trolley.</p> <p>The Non Prescribed Approved Medication (Standing Orders) document has been individually signed by each GP, however it does not meet the 2012 Standing Orders Guidelines (number of doses which can be given is not included).</p> <p>Records of fridge temperature monitoring were not sighted.</p> <p>There was a discrepancy in the number of controlled drugs in the cupboard and the controlled drug register. Twelve medications are recorded in the controlled drug register and 11 are in the cupboard. This had been previously highlighted and is occurring because staff are counting out one (1) even though there are two (2) tablets in the blister pack (refer # 1.2.4).</p>
Finding: <p>The medicine management system does not meet legislative requirements, guidelines or best practice with regard to prescribing and storage.</p>
Corrective Action: <p>Provide evidence that the medicine management system meets legislative requirements, guidelines or best practice with regard to prescribing and storage.</p>
Timeframe (days): 7 (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 Moderate
Evidence: <p>During the observed medication round the carer is sighted placing medications into her hand and then placing them on the table where the resident is sitting. The carer then moves on prior to observing if the medication is taken. It is reported by the Nurse Manager that this is not consistent with the medication competency training.</p> <p>The medication competency register has not been maintained. Not all staff who administer medication have current competency assessment; this includes the manager/RN. These are areas requiring improvement. Staff signatures on medication administration sheets were not on the competency register (two names were absent and one was not signed off as competent).</p>
Finding: <p>Evidence of medication competency has not been maintained.</p>
Corrective Action: <p>Provide evidence that all staff administering medication are competent to do so.</p>
Timeframe (days): 30 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The nutritional needs of residents are met. The residents nutritional status is assessed on admission and needs identified. Level of assistance required is recorded. All residents are weighed monthly. The cook is aware of likes and dislikes and provides alternatives if required. Fluids and snacks are readily available.

There is a summer and winter menu cycle. The menu plans are appropriate for residents in an aged care residential setting and have been reviewed by a dietitian. The cook interviewed reports that deviations to the menu are sometimes required, however a record of this has not been maintained and an improvement is required.

The kitchen is maintained in line with food hygiene practices. This includes complying with food hygiene standards and ensuring staff have the required training. Regular monitoring includes stock control and temperature monitoring of fridges, freezers and meat.

Residents interviewed express satisfaction regarding meals. Meals sighted during the audit are observed to be well presented and sufficient in volume.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: PA Low

Evidence:

The cook is interviewed and reports that on occasion there is a deviation to the menu. This may occur due to the availability of fresh produce or at the request of the residents. Records of deviations to the menu are not maintained.

Finding:

Deviations to the menu are sometimes made, however a record of this has not been maintained.

Corrective Action:

Maintain records of deviations to the menu.

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

Criterion 1.3.13.2 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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: PA High

Evidence:

There is an area requiring improvement relating to the Building Warrant of Fitness (BWOFF) for Kohatu Rest Home that expired on the 7 March 2014. The owner reports they have contacted the company responsible for issuing the BWOFF several times in the past month and that the owner has been told by the company that they are waiting for the report on the automatic fire doors before issuing the BWOFF. The manager/RN contacted the company during the audit and discovered that no one has visited Kohatu Rest Home to survey the automatic fire doors, and an arrangement was made for someone to visit the facility.

A second lounge has been divided to create a single bedroom since the last audit. An internal wall has been erected, and a door inserted, so that this room shares an ensuite with an existing bedroom. The new bedroom has a call bell and appropriate heating. The manager/RN and owner advise they did not require building consent and the number of beds provided has not altered as double rooms are only used as single rooms.

Not all ARC requirements are met.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA High

Evidence:

There is an area requiring improvement relating to the Building Warrant of Fitness (BWOFF) for Kohatu Rest Home that expired on the 7 March 2014. The owner reports they have contacted the company responsible for issuing the BWOFF several times in the past month and that the owner has been told by the company that they are waiting for the report on the automatic fire doors before issuing the BWOFF. The manager/RN contacted the company during the audit and discovered that no one has visited Kohatu Rest Home to survey the automatic fire doors, and an arrangement was made for someone to visit the facility.

Finding:

The BWOFF for Kohatu Rest Home expired on the 7 March 2014.

Corrective Action:

Provide evidence of a current BWOFF.

Timeframe (days): 7 (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: Restraint minimisation is promoted and alternatives provided where able. The restraint minimisation and safe practice policy includes definitions for enablers and restraint. Staff training on the use of restraints/enablers and alternatives is provided. Staff interviewed report the rest home currently has no restraints or enablers in use and this is confirmed through observations during the audit.

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

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

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

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

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: PA Low

Evidence:

An appropriate surveillance programme is implemented and suitable to the services provided at the rest home. Standard definitions are used to identify infections for surveillance. Infections data is collected and collated monthly and reported at staff meetings, however not all infections have been added to the surveillance data and an improvement is required.

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: PA Low

Evidence:

The Nurse Manager has implemented a new process (and document) for capturing surveillance data. Infection reports are required to be completed for each reported infection. It is noted in the residents' files sampled that two reported infections have not been documented using the required form, and therefore have not been added to the monthly surveillance data. This system is yet to be fully implemented.

Finding:

Not all infections have been added into the surveillance data.

Corrective Action:

Include all infections in surveillance data

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)