

Mercy Assisi Home & Hospital Hamilton 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

Atawhai Assisi Home and Hospital is part of the Mercy Healthcare Auckland Group. The Sisters of Mercy and the pastoral care team are active in their support of both residents and staff, with quality of life of each resident seen as a core value of the service. The service has a culture of looking for ways to improve and this is reflected in the quality and risk systems in place. Feedback received at the time of audit reflects that the quality of care, including end of life care, are recognised strengths of the service.

Atawhai Assisi provides rest home and hospital level of care for up to 87 residents. At the time of audit there are 45 residents at hospital level of care and 37 at rest home level of care. At the time of audit there are no younger disabled residents at the service.

There were two areas of required improvement identified at the previous audit related to advance directive forms and the monitoring of the temperature of the medicine fridges. These areas are now addressed, with the improvements imbedded into practice. There is one new area for improvement identified at this audit related to the labelling of foods in the kitchen.

The service has demonstrated a high quality of service provision in the areas of infection control surveillance and the team approach to care, which exceeded the required full attainment rating and has gained a continuous improvement rating.

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

Indicator	Description	Definition
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 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.
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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.		Standards applicable to this service fully attained.
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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 low risk.
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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.
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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.
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Infection Prevention and Control as at 26 February 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>All standards applicable to this service fully attained with some standards exceeded.</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:	Mercy Assisi Home & Hospital Hamilton Limited		
Certificate name:	Mercy Assisi Home & Hospital Hamilton Limited		
Designated Auditing Agency:	The DAA Group Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Atawhai Assisi Home & Hospital		
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); 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:			82

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

Sample Totals

Total audit hours on site	16	Total audit hours off site	10	Total audit hours	26
Number of residents interviewed	6	Number of staff interviewed	16	Number of managers interviewed	4
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	4
Number of medication records reviewed	12	Total number of staff (headcount)	92	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

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

I confirm that:

a)	I am a delegated authority of The DAA Group Limited	Yes
b)	The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	The DAA Group 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	No
g)	The DAA Group Limited has provided all the information that is relevant to the audit	Yes
h)	The DAA Group Limited has finished editing the document.	Yes

Dated Wednesday, 2 April 2014

Executive Summary of Audit

General Overview

Atawhai Assisi Home and Hospital is part of the Mercy Healthcare Auckland Group. The Sisters of Mercy and the pastoral care team are active in their support of both residents and staff, with quality of life of each resident seen as a core value of the service. The service has a culture of looking for ways to improve and this is reflected in the quality and risk systems in place. Feedback received at the time of audit reflects that the quality of care, including end of life care, are recognised strengths of the service.

Atawhai Assisi provides rest home and hospital level of care for up to 87 residents. At the time of audit there are 45 residents at hospital level of care and 37 at rest home level of care. At the time of audit there are no younger disabled residents at the service.

There were two areas of required improvement identified at the previous audit related to advance directive forms and the monitoring of the temperature of the medicine fridges. These areas are now addressed, with the improvements imbedded into practice. There is one new area for improvement identified at this audit related to the labelling of foods in the kitchen.

The service has demonstrated a high quality of service provision in the areas of infection control surveillance and the team approach to care, which exceeded the required full attainment rating and has gained a continuous improvement rating.

Outcome 1.1: Consumer Rights

The service has an easily accessed, responsive and fair complaints process. There is an up-to-date complaints register maintained that includes all complaints, dates, and actions taken. Written and verbal complaints are recorded in the log. Residents and family/whanau report they receive full and frank information and open disclosure from the staff.

There is a previous area of required improvement to ensure advance directive forms are valid and signed by the resident where competent. This is now addressed and an improvement implemented since the last audit.

Outcome 1.2: Organisational Management

The strategic and business plans, key performance indicators, and policies in place provide direction to ensure that services of an appropriate standard and scope are provided. Strong guidance and support is received from the Board of Directors of Mercy Healthcare. The service is managed by an experienced Chief Executive Officer (a registered nurse) with appropriate qualifications who has been in the role for over 20 years.

Atawhai Assisi has a comprehensive quality and risk management system which is embedded and understood by staff. The internal auditing plan has involvement from the staff who actively participate in the quality programme. Monitoring of compliance is conducted through the quality and risk management systems. Adverse events are reported, monitored and corrective action plans are in place. The Opportunity for Improvement committee structure is in place.

provides regular forums for discussion, monitoring and follow-up of service wide issues, risks, complaints, incidents, and health and safety matters. There are policies and procedures that cover all aspects of the services provided.

Human resources management processes are conducted in accordance with good employment practice and meet the requirements of legislation. New staff receive an orientation/induction programme that covers the essential components of the service provided. There is a system in place to identify, plan, facilitate, and record ongoing education for staff to provide safe and effective services to the residents. There are clearly documented and implemented processes which determine staffing levels and skill mixes in order to provide safe service delivery.

Outcome 1.3: Continuum of Service Delivery

The organisation provides appropriate service provision for residents at rest home and hospital level of care. Each stage of service provision is undertaken by suitably qualified and experienced staff within timeframes to comply with contractual requirements and to ensure all residents' needs are met. Changes to residents' needs are well responded to, and for temporary changes of care, a short term care plan is put in place.

The service provided is resident centred and staff work as a team to identify and meet all identified needs. Resident services are very well coordinated and this is an area that has gained a higher level of achievement. Resident and family/whanau interviews confirm a high level of satisfaction with all services offered.

The activities programme supports the interests, needs and strengths of the residents. Documentation identifies the regularity of review and planning undertaken to meet residents' wants. The programme is assisted by the use of volunteers and there is strong community involvement.

A safe and timely medicine management system is implemented by the service. Staff who administer medicines are competent to undertake the role. Regular medication reviews are undertaken by the GP with specialist input as required.

Residents express satisfaction with the food and fluid offered at the service. The menus have been approved by a registered dietitian and individual resident reviews are undertaken as required. One area identified for improvement relates to not all decanted food having expiry dates or showing date of opening.

Outcome 1.4: Safe and Appropriate Environment

The facility has a current building warrant of fitness. There have been no major changes to the layout of the facility or changes that are required to the evacuation plan since the last audit.

Outcome 2: Restraint Minimisation and Safe Practice

The facility demonstrates that the use of restraint is actively minimised. At the time of audit there is one resident with the use of an enabler. Enabler use is voluntary and the least restrictive option to meet the needs of the resident with the intent of maintaining safety and independence.

Outcome 3: Infection Prevention and Control

The results of surveillance of infections are analysed and reported to staff and management. The service works proactively to reduce infections and where trends are identified, the service implements appropriate corrective actions. The infection surveillance data is externally benchmarked and this data identifies the service sits in the lower percentile compared to other aged care facilities. This is an area of particular strength for the service and has gained a continued improvement rating.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	1	15	0	1	0	0	0
Criteria	2	36	0	1	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	33
Criteria	0	0	0	0	0	0	0	62

Corrective Action Requests (CAR) Report

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 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	Not all decanted dry food in the pantry shows an expiry or use by date. On the day of audit not all opened food stuff identifies what day it is placed in the chiller this included cheese, cut up tomatoes and pureed	Ensure all aspects of food and policy guidelines are met in relation to storage.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				fruit.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Criterion 1.3.3.4	The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	CI	All six of six resident file reviews (three hospital and three rest home) show input from all team members which are well documented, discussed and reviewed at planning meetings. Each team members input is valued and findings are coordinated to ensure all appropriate interventions are put in place in a timely manner. Both residents' records reviewed demonstrate a strong team approach which has improved the wellbeing of the resident. This includes specialist input as required. Both residents have had their level of mobility improved to encourage independence and all staff implement and understand required changes. Staff report on the success of the changes made.
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.	CI	
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.	CI	All corrective actions identified from benchmarking or trending are discussed at management and staff level. Once implemented the corrective action or quality improvement are reviewed and evaluated. One example sighted shows that in August 2013 there were seven urinary tract infections. Working proactively the service decided to target urinary tract infections as an area for improvement. An extra fluid round was put in place and each residents drink likes were catered for to try to increase the fluid uptake. This included the introduction of jelly for residents who do not like to have fluids. The review process included the process to be undertaken at different times of the day. Evaluation concludes that 4pm is found to be the time with the best uptake. The December 2013 urinary tract infections decreased to three.

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 six of six residents (four rest home and two hospital) and four of four family/whanau report they receive full and frank information and open disclosure from the staff. The incident forms sighted record that the family are notified of the incident/accident. The six of six residents' files sighted (three rest home and three hospital) provide evidence of family/whanau communications. Residents and family members interviewed state they have the opportunity to talk to management or staff.

All residents at the time of audit speak English. The service has policies and procedures in place for accessing interpreter services when this is required

The ARRC 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 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: FA
Evidence: <p>The previous corrective action request at 1.1.10.7 was made to ensure advance directive forms are valid and signed by the resident where competent. This is now addressed and an improvement implemented since the last audit.</p> <p>The six of six resident files reviewed have an advance directive signed when the residents were competent to do so. The advance directives sighted are signed by the resident and comply with legislative requirements. The nine of nine care staff (six caregivers, two RNs and one EN) interviewed demonstrate knowledge on acting on advance directives.</p>

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

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: <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. Complaints forms are accessible at the entrances to the service. The six of six residents and two of two family/whanau report that these are easily accessible if they require them. Written and verbal complaints are recorded in the log. The complaints report form contains the dates of the complaint and the date the complaint is formally acknowledged, records if advice is given on the HDC complaints process and if the complaints brochure (which outlines the complaint process and access to advocacy services) is given, the nature of the complaint, investigations, actions and recommendations, and if the complainant was satisfied with the outcome. If the complaint is not resolved within 14 days, the complainant is notified of progress monthly (or more frequently if required).</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. The 'non conformance/complaints log' records the date the complaint is reviewed, the description of the event, description of the corrective actions taken, review date and completion date. The complaint log records that 10 complaints received in 2013 are satisfactorily resolved. There is one ongoing complaint at the time of audit.</p>

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

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

Attainment and Risk: FA
Evidence:
Finding:

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and reviewed annually (the 2013-2014 business, quality and risk plan is sighted). The plan for 2014-2015 is currently under review and schedule for completion by April 2014. Atawhai Mercy Assisi is part of the Mercy Healthcare Auckland Group. Mercy Healthcare Auckland is a subsidiary of Mercy Ministries Trust, who manage the apostolic works of Nga Whaea Atawhai o Aotearoa Sisters of Mercy New Zealand. The Board of Mercy Healthcare Auckland is responsible for the stewardship of the Mercy Health Auckland group (which includes Atawhai Mercy Assisi). The mission and values of Atawhai Mercy Assisi are to build an organisational culture based on the Mercy values through the development of the Mission Team structure to ensure it has a strong presence in the organisation. The service focuses on one of the values each year and integrates this into ongoing education and learning. The focus of 2014 at</p>

Atawhai Mercy Assisi is 'respect for human dignity'.

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services. The Chief Executive Officer (CEO) is an experienced registered nurse (RN) with a current practising certificate (sighted copy). The CEO has been in the role for 22 years. The CEO has attended over eight hours education related to the management of aged care services in the past 12 months. This includes attendance and presentation at an Aged Wise/Association of Gerontology conference, Safety course for managers, introduction of archiving and accounting standards for charitable organizations. The CEO also attends ongoing education on relevant issues in relation to common conditions in aged care, medicine management and palliative care. The CEO has completed a Diploma in Health Services Management and was a member of the Standards New Zealand review committee for the Health and Disability Standard and the Restraint Standard. The CEO reports to the general manager of Mercy Health Care. The CEO is supported by clinical managers for the rest home and hospital level of care services.

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The sighted quality and risk management guidelines identify objectives and action planning and support to reach identified goal. Strategic directions are based on the services mission and values. There are strategic objectives for the service, human resource management, financial management, facility and infrastructure and new developments. Each objective has key performance indicators (KPI) and targets. The KPIs and targets are regularly monitored by the CEO. The staff have ongoing education on quality issues at the core education study days. The organisation has a quality and risk management system which is understood and implemented by staff, as confirmed at interview with the 16 staff (six caregivers, two RNs, one EN, two DTs, two kitchen staff, one physiotherapists and two pastoral coordinators).

The policies and procedures are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. Critical policies (eg infection control) are reviewed two yearly, all other policies are reviewed three yearly with the exception of governance policies which are reviewed five yearly. Policies are reviewed sooner if there are legislative changes. Policies sighted are reflective of good practice. There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures are accessible by staff.

Key components of service delivery are explicitly linked to the quality management system. The quality and risk management system is closely linked with the health and safety, complaints management and infection control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of the service delivery. The service has an annual internal auditing event titled "Action Albert" where it is identified what areas require an internal audit and these are delegated to staff to complete. The opportunities for improvement (OFI) committee review the results and recommendations from the internal auditing process. The service use an external Australasian benchmarking service, with these benchmarking results integrated into the organisational quality system, with trends, analysis or areas for improvement noted and discussed at OFI meetings. There were numerous examples of links into the quality management system, quality projects and service improvements documented and discussed as evidenced in meeting minutes, CEO and the two care managers interviews.

Corrective action plans are developed from identified areas of improvement through the internal audits, hazards, incident forms, satisfaction surveys and the complaints management process. Corrective action request forms document the non conformance, identification of the root cause, proposed actions and quality improvement recommendations, review of the implementation through the OFI meeting are signed off when the recommended actions are implemented. A re-audit of the issue is conducted to review if the actions implemented are affective in minimising or eliminating the area of concern.

Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted includes the identified risks, how these are monitored, the severity of the risk and if the implemented actions can isolate, eliminate or minimise the risk. The risk register is maintained by the Health and Safety officer. The risk register is maintained for each area of the service.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (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>Health and Safety policy identifies the statutory and regulatory obligations in relation to essential notification reporting. A serious harm notification form and report template is available. The staff understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The CEO reports that there have been no major incidents or essential events that have required reporting to the relevant authority.</p> <p>A review of 10 recent incident and accident reports identifies a wide range of incidents are reported by staff and data is collected to identify trends. If an area for improvement is identified through the events reporting process and complaints or internal audits, this is addressed through corrective action planning and includes quality projects. Interviews of nine of nine care staff confirms staff have a good understanding of reporting of adverse events. The nine of nine care staff interviewed demonstrate an understanding of when to complete an incident form.</p> <p>The ARRC 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: FA

Evidence:

Professional qualifications are validated, including evidence of registration and scope of practice for the professional staff. Annual practising certificates are sighted for all staff that require them.

There are processes implemented for the appointment of appropriate staff to safely meet the needs of residents. The six of six staff files reviewed (two RNs, two caregivers, one physio assistant and one diversional therapist) demonstrate appropriate recruitment and employment processes. These include recruitment and employment process for advertising, interview process, reference checking, police vetting and qualification validation. There is a performance appraisal system, which is conducted at least annually for all staff. The newer staff also have a performance review after the first three months of employment.

New staff receive an orientation/induction programme that covers the essential components of the service provided. The staff files reviewed evidence an orientation and the six of six caregivers interviewed confirmed they received an orientation that was effective in preparing them to work in the service.

There is a system in place to identify, plan, facilitate, and record ongoing education for staff to provide safe and effective services to the residents. The completed annual training time table for 2013 is sighted, as well as the planned education for 2014. The education provided in 2013 is appropriate to rest home and hospital level of care. The Aged Care Education (ACE) training programme is the primary education focus for the caregivers. All caregivers who do not have a national qualification are required to commence the ACE programme within three months of employment. All staff are required to complete the core education study days annually. The core education study days are provided for the RNs, ENs, care staff and other staff members. The content of the core study days includes quality, restraint minimisation and safe use, infection prevention and control, fire, health and safety, organisational mission and resident rights and manual handling. Staff also have access to external education, when this is attended by staff, the staff provide written feedback on the key points of the course, what learning has occurred, the relevance to the service and suggestions for improvements/changes that can be implemented/actioned.

The six of six residents and two of two family/whanau report satisfaction with care provided.

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

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

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

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

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

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

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

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

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

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

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA
Evidence: <p>The staffing ratios are documented in policy for both the hospital and rest home setting. The service has a policy on replacing staff to ensure the clinical care can be maintained.</p> <p>There is a clinical manager (RN) for the rest home and a clinical manager (RN) for the hospital who are on duty mornings Monday to Friday, with three of these days being additional to the RN staff on the floors (two days a week the care managers work as the RN on duty). The rosters confirm the following:</p> <ul style="list-style-type: none">- morning in the hospital (maximum 46 residents) – two RNs and 11 caregivers (staggered start and finish times) and in the rest home (max 41 residents) one RN and four caregivers.-afternoon shifts in the hospital there are two RNs and eight caregivers (staggered start and finish times) and on the rest home one EN and three caregivers- on night shift there are two RNs and four caregivers (or three caregivers and one EN) to cover the rest home and hospital sections. <p>There are staggered start and finish times for the three diversional therapists each day, to cover from 9am to 7pm. There are adequate laundry, cleaning (contracted), kitchen, physiotherapy (contracted) and physiotherapy assistants to cover the needs of the resident. The service has a number of volunteers that assist with activities, companionship and transport for the residents.</p>

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c.i; 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: <p>Each stage of assessment, planning, provision of care and review/evaluation is undertaken by suitably qualified staff that are competent to perform their role. Six of six resident file reviews, (three rest home and three hospital level care), include one resident from each level of care being reviewed. All clinical assessments are undertaken by a registered nurse (RN) or enrolled nurse (EN) with RN sign off as appropriate.</p> <p>The file reviews confirm that the initial assessment and initial care plan is developed on the day the resident is admitted and the and long term care plans are developed and completed within three weeks of admission. The care staff are suitably experienced and encouraged to complete a recognised Aged Care Education (ACE) qualification. This process is overseen by a nominated educator/assessor.</p> <p>The initial and ongoing assessments are undertaken using appropriate assessment tools which include pressure area care, independence of activities of daily living, falls risk, pain, continence and mini mental assessments as required. Residents’ physical, psychosocial, cultural and spiritual needs are identified. The kitchen manager undertakes a dietary profile and social and spiritual needs are assessed by dedicated pastoral care staff and the diversional therapists. All residents have a full physiotherapy review as part of the admission assessments. An individualised mobility plan is completed and maintained by the physiotherapist and the physiotherapy</p>

assistants. Physiotherapy staff have input into planned exercise groups.

Information gathered during the assessment process informs individualised residents' care plans. The care plan identifies the goals, interventions and outcomes to show how the resident's needs are met by the service. Care plan reviews are conducted at least six monthly and a full multidisciplinary review is undertaken at least annually. Documentation sighted in six of six resident file reviews and interviews with six of six residents and four of four family/whānau members confirm they are involved in every aspect of care planning and always kept very well informed.

The resident file reviews evidence the initial medical review is conducted within two days of admission (where required). This usually occurs on the day of admission. All file reviews contain admission check sheets showing all process are completed within required timeframes. Ongoing medical reviews are conducted monthly or at least three monthly when the resident is assessed as stable. More frequent reviews are sighted for residents who have documented changes to their health needs caused by acute situations, such as an infection or there is deterioration in the resident's overall health.

The service is co-ordinated in a manner that promotes continuity of care by all members of the team. This is an area which is undertaken to a very high level which has gained a continued improvement status. Resident progress notes are completed by all providers who have input into care provision. Progress notes are updated by exception reporting and sighted to have been completed at least twice daily in six of six resident file reviews. A handover is provided at the start of each shift, and clinical staff report that adequate information is shared to provide safe, timely and appropriate care to meet residents' needs.

Interviews with six of six residents (four rest home and two hospital) and four of four family/whānau members report the residents receive care that meets their needs in a caring and professional manner. The GP reports that they are extremely happy with the quality of care provided. The GP also reports that there is a good integration of services, with specialist input as required, to meet the needs of the residents with a specialised focus on end of life care.

Tracer one: A hospital level care resident

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

Tracer two:

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

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

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

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

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

Criterion 1.3.3.4 (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: CI
Evidence:
<p>The service offered to all residents is coordinated in a manner that promotes continuity of service delivery and promotes a team approach to all care that is put in place. This begins at the time of the initial assessment and as shown in six of six file reviews all appropriate team members are included in resident care planning process with resident and family/whanau input. Members of the team include nursing staff, physiotherapy, kitchen manager, pharmacy, diversional therapy, the GP, pastoral advisors and specialists as required.</p> <p>Each resident review includes all team members giving a written and oral report which is evaluated and new interventions are put in place as required ensuring informed continuity of care for the resident. Having fully attained this criterion the service can in addition clearly demonstrate a review process which includes analysis and reporting systems which result in improvement to service delivery to individual residents to ensuring continuity of care which either improves the resident's health status or maintains the resident in a state of maximum wellness or a peaceful death.</p>

Finding:

All six of six resident file reviews (three hospital and three rest home) show input from all team members which are well documented, discussed and reviewed at planning meetings. Each team members input is valued and findings are coordinated to ensure all appropriate interventions are put in place in a timely manner. Both residents' records reviewed demonstrate a strong team approach which has improved the wellbeing of the resident. This includes specialist input as required. Both residents have had their level of mobility improved to encourage independence and all staff implement and understand required changes. Staff report on the success of the changes made.

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Six of six (three hospital and three rest home) long term care plan reviews have interventions based on the resident's identified needs. The service has paper based and electronic assessments (interRAI) and care planning records. Care plans are individualised to the resident's assessed needs and are appropriate. Short term care plans are sighted in four of the six record reviews for wound care and/or infection management.

Both the hospital and rest home level care residents' reviews undertaken have recorded interventions that are appropriate to meet their changing needs for all aspects of care. (Refer comments in criterion 1.3.3.4). It is identified how post surgical procedures are managed, with specialist input as appropriate with all required follow up actions shown on either short or long term care plans.

Interviews with six of six caregivers, two RNs, one EN, two diversional therapists, the physiotherapist and the GP report the care plans provide accurate information regarding the individual needs and care required for the residents. The implementation of care meets all the needs of residents as confirmed during interview with four of four rest home and two of two hospital level care residents and four of four family/whanau members.

The GP reports that all staff deliver a very high level of care and their knowledge and skills ensure residents get extremely good care and that he is proud to associated with the service.

ARRC requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>As part of the admission process a full diversional therapy assessment is undertaken as part of the social assessment to identify resident's strengths and interests. The family/whanau are involved in this assessment process whenever possible. This includes important events that are relevant to the resident which are included in the activity planning process. This is confirmed in six of six resident file reviews (three hospital and three rest home).</p> <p>Activities are planned monthly by the team of diversional therapists with physiotherapy input as appropriate. This monthly review is used to evaluate the activities which are in place and to seek new and innovative ideas to ensure all resident social, physical and cognitive needs are being met. Activities are put in place for all acuity levels and to reflect individual resident interests. Activities are well resourced and this includes regular van and bus trips into the community. Residents are supported to maintain community contacts and the diversional therapists interviewed report that there are residents who go out with family and friends, trips included the local Operatunity stage shows, The Working-mens Club, special services at Hamilton cathedral, visits to preschools and that the service is partners with a special school which they work with a group of students aged between 16 and 21 years.</p> <p>Volunteers from the local community who assist with activities, including van trips, undertake an appropriate orientation. A discussion was held related to the volunteers being able to manage a medical emergency and it is reported they carry a cell phone and have a printed profile for each resident on the trip which identifies falls risk, toileting requirements, resuscitation status and has a photograph of the resident. The van has a first aid box but the service does not currently ensure the volunteers hold a first aid certificate. This may be looked at in the future. The bus trips which take ten residents always have a member of staff who holds a current first aid certificate.</p> <p>A daily record chart (sighted) is kept for all activities residents attend. The diversional therapists write any concerns in the resident's progress notes as appropriate and are part of the resident care planning review team. (See comments in criterion 1.3.3.4).</p>

Interviews with six of six residents confirm they enjoy the range of activities offered and that all their needs and interests are included in what they do.

ARRC requirements are met.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Six of six resident care plan reviews (three hospital and three rest home level care), identify that evaluations and reviews are undertaken at least six monthly or sooner if there are changes to the resident's condition. Both residents' files reviewed show appropriate changes are made to interventions with each new issue that is reported. This includes post surgical cares and specialist health care provider recommendations.</p> <p>Short term care plans identify issues that will be resolved and do not require ongoing care such as infections or wound care. Four of the six resident file reviews have appropriately completed short term care plans. All care plans have resident centred goals and if these are not being met new interventions are put in place as required. Whilst all goals are evaluated and it is possible to locate the required information, some interventions are shown as an evaluation. This was discussed with the two RN care managers at the time of audit and it was agreed that this would be much clearer if evaluations are uniformly documented.</p> <p>Interviews with six of six residents (four rest home and two hospital level) and four of four family/whanau members confirm they are fully engaged with care reviews. This is evidenced by family/whanau signing the care plan to say it has been discussed and that interventions are agreed upon. Family/whanau are kept fully informed of any</p>

concerns or issues that arise.

ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Medicines for residents are received from the pharmacy in the medico packs. Upon arrival at the facility they are signed for and checked for accuracy against the resident's medicine chart by a RN and again at time of administration. This includes non packaged medicines that are prescribed for individual residents such as liquids and warfarin. Regular medicine reconciliations processes occur and the pharmacist undertakes a review of individual resident medicine files yearly as part of the multidisciplinary review process. Safe medicine management practices were observed in both the hospital and rest home areas on the day of audit which meet all policy requirements.

Medicines are stored in locked cupboards in locked treatment rooms. The controlled drugs are stored in a locked safe, two staff sign the register at each administration and a regular stock count is undertaken. This is weekly in the hospital and at the end of each page for the rest home. It was discussed at the time of audit that the rest home should also undertake weekly counts for controlled drugs and this practice has commenced. The service's medicine fridge is monitored at least weekly and temperatures are within recommended guidelines. The fridge is used for non-vaccine medications. This was an area identified for improvement in the previous audit and is now fully attained.

The 12 of 12 medicine chart reviews identify that the GP reviews medications at a minimum of three monthly and that the date, medicine name, dose, time of administration and any allergies are clearly shown. All medicine charts have each medicine individually prescribed. All sighted signing sheets are fully completed and indicate who has administered the medication with appropriate identification if the resident has refused to take the medication or in one instance it is shown as withheld as it was a sleeping tablet for a resident who was sound asleep at the time of the medication round. Competencies sighted for all staff that require them.

There are standing orders in place which are for items that are deemed as over the counter medicines such as paracetamol, ural and nitro lingual spray. The contraindications are located on a separate sheet and it was discussed on the day of audit that the service may benefit from having this information on the same sheet of paper as the instructions for use.

The service implements a system which allows residents to self-administer medicines if they are assessed as competent to do so. This process includes the use of a locked drawer in the resident's bedroom.

The ARRC requirements are met.

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence:
<p>The rotating menu, with seasonal variations, is approved by a registered dietitian in 2009 as being suitable for aged care residents. The service intends to have a full menu review during 2014.</p> <p>The service has a dietitian on call and individual residents are reviewed as required. One example sighted relates to a resident with increased potassium levels. Full dietitian instructions have been implemented by the service.</p> <p>A nutritional profile is completed for each resident as part of the admission process and information is shared with the kitchen staff and is very clearly documented. The service ensures all needs, wants, dislikes and special diets are catered for. The kitchen manager and two kitchen staff confirm that all dietary requirements can be met</p>

including additional, modified or special requirements. Policy indicates that a resident with an unexplained weight change of three kilograms or more is reviewed by the food service manager and a registered nurse. If the weight loss continues, the resident is referred to the dietitian. This requirement is implemented by the service as confirmed in documentation sighted. The kitchen manager reports there is excellent communication between nursing staff and kitchen staff which allows all residents likes and dislikes to be met.

Interviews with six of six residents (four rest home and two hospital) along with four of four family/whānau members confirm they are very satisfied with the food provided.

All aspects of food procurement, production, preparation, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken twice daily and meet requirements. All ready to serve foods are kept at appropriate temperatures in electric Bain Maree. The kitchen manager states that food temperatures are regularly taken but not recorded as temperatures fall within the safe food guidelines. (Food temperatures are not a requirement for this standard). There is a comprehensive cleaning schedule implemented which is overseen by the kitchen manager. A recent change to the manner in which food is disposed of has been undertaken by the service to meet local Hamilton Council requirements. This involved a change of sink traps and filter being installed and the removal of all waste masters. Food waste is now bagged and binned twice daily. The policies and procedure have been updated to show this change.

One area identified for improvement relates to not all decanted or open foodstuff being labelled or showing appropriate dates.

ARRC requirements are met

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: Some dried food stuff in the pantry is decanted into containers and no expiry dates or dates of purchase can be found. The service has a system in place to indicate the day and date prepared food is stored in the chiller, however this system is not always followed.
Finding: Not all decanted dry food in the pantry shows an expiry or use by date. On the day of audit not all opened food stuff identifies what day it is placed in the chiller this included cheese, cut up tomatoes and pureed fruit.
Corrective Action: Ensure all aspects of food and policy guidelines are met in relation to storage.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Attainment and Risk: FA

Evidence:

The sighted building warrant of fitness expires April 2014. There have been no major changes to the service.

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 service has one resident with enabler use. 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 resident independence and safety. This resident has requested the use of one bed side rail to assist with mobility and the feeling of safety when in bed. The core study day covers the use of restraint and enablers. The quiz after the session reviews the learning at the session and there is a question on what is an enabler. The six of six caregivers interviewed demonstrate an understanding that enablers are voluntary with the intent of maintaining resident independence and safety.

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: CI
Evidence:
<p>Surveillance data that is collected meets Health and Disability Standard requirements and the infection control programme that is in place. Infection control data collected includes urinary tract infections, chest infections, wound infections, diarrheal conditions, eye and ear infections and multi-resistant organisms. The monthly report of collected data is provided to senior management and floor staff.</p> <p>The service has a robust data review process in place which identifies the analysis and benchmarking and trending of all infection control data. Any variance in the number of infections is fully investigated by the infection control coordinator and taken to the head of department meeting in a written report. The service benchmarks the infection surveillance results with an external quality agency and receives quarterly benchmarking data which identifies that the service sits in the lower percentile for overall infection rates when compared with other age care services. The service documents actions taken to show how they work proactively to achieve infection reductions. This is an area that the service undertakes to a very high standard and has gained a continued improvement rating.</p> <p>All staff members are responsible for the reporting of suspected infections to the infection control coordinator. The infection control coordinator is responsible for ensuring</p>

appropriate action, notification and follow-up is undertaken. Surveillance data sighted identifies that there was a confirmed norovirus outbreak in October 2012 which was very well contained affecting five staff and seven residents located in one area of the facility. All appropriate notification notices and documentation is available to show this was managed according to correct outbreak procedure requirements.

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: CI

Evidence:

Having fully attained this criterion the service can in addition clearly demonstrate a review process which includes analysis and reporting systems which result in improvements to service provision and resident safety as a result of the actions being implemented. The service ensures all surveillance data that is collated is trended monthly at the facility and that any areas of concern are written up as a corrective action. Information is reviewed, evaluated and acted upon to assist in achieving infection reduction numbers. The service is proactive and demonstrates the use of quality initiatives to further reduce infection rates.

Finding:

All corrective actions identified from benchmarking or trending are discussed at management and staff level. Once implemented the corrective action or quality improvement are reviewed and evaluated. One example sighted shows that in August 2013 there were seven urinary tract infections. Working proactively the service decided to target urinary tract infections as an area for improvement. An extra fluid round was put in place and each resident drink likes were catered for to try to increase the fluid uptake. This included the introduction of jelly for residents who do not like to have fluids. The review process included the process to be undertaken at different times of the day. Evaluation concludes that 4pm is found to be the time with the best uptake. The December 2013 urinary tract infections decreased to three.

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