

Wilding International Limited

Current Status: 20 January 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Armourdene Rest Home provides care for up to 28 rest home residents. At the time of the audit, there are 22 residents in the service.

The owner/manager has a background in corporate management and is supported by a senior registered nurse who has a background in aged care nursing for over 15 years. There is also an administration manager who maintains quality systems.

Three of the four improvements required at the previous audit around orientation, first aid and integration of records have been addressed.

One improvement required at the certification audit remains around the quality programme.

Further improvements are required to the following: documentation that family have been informed following an incident, including satisfaction survey data collation in the quality programme, documenting an internal audit schedule and discussion of all aspects of the quality programme in staff meetings, care planning, resident agreements, medication administration and food services.

Audit Summary as at 20 January 2014

Standards have been assessed and summarised below:

Key

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

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

Consumer Rights as at 20 January 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 20 January 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 20 January 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 20 January 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 20 January 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 20 January 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>Standards applicable to this service fully attained.</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:	Wilding International Limited		
Certificate name:	Wilding International Limited		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Armourdene Rest Home		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	Start date: 20 January 2014	End date: 20 January 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			28

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	7
Other Auditors		Total hours on site		Total hours off site	0
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	1

Sample Totals

Total audit hours on site	8	Total audit hours off site	8	Total audit hours	16
Number of residents interviewed	5	Number of staff interviewed	7	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	52	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Monday, 24 February 2014

Executive Summary of Audit

General Overview

Armourdene Rest Home provides care for up to 28 rest home residents. At the time of the audit, there are 22 residents in the service. The owner/manager has a background in corporate management and is supported by a senior registered nurse who has a background in aged care nursing for over 15 years. There is also an administration manager who maintains quality systems. Three of the four improvements required at the previous audit around orientation, first aid and integration of records have been addressed. One improvement required at the certification audit remains around the quality programme. Further improvements are required to the following: documentation that family have been informed following an incident, including satisfaction survey data collation in the quality programme, documenting an internal audit schedule and discussion of all aspects of the quality programme in staff meetings, care planning, resident agreements, medication administration and food services.

Outcome 1.1: Consumer Rights

Armourdene Rest Home provides care and support that focuses on the individual with residents and relatives praising the services provided. There is an open disclosure policy and an interpreter's policy in place. Staff have a good understanding of these policies. Interpreter services are available if needed. Families of the resident's report the manager and staff keep them informed of their family member's status. Complaints processes are implemented and complaints and concerns are actively managed and documented with a complaints register completed by the owner/manager. The service encourages the documentation of verbal complaints as a tool to improve quality of service delivery. An improvement is required to the documentation that family have been informed following an incident.

Outcome 1.2: Organisational Management

There is a documented mission statement & objectives. The service's policies are reviewed regularly. Staff have access to manuals in hard copy. Policies are up to date. Clinical guidelines are in place to assist care staff. The service collects internal data for monitoring purposes. There is documented evidence of corrective action plans in place for internal audits; however improvements are required around including satisfaction survey data collation in the quality programme and documenting an internal audit schedule and discussion of all aspects of the quality programme in staff meetings. The service has a risk management programme. Practising certificates are held in a central location for all registered, clinical staff. Policies around recruitment, selection and appointment of staff are in place. Armourdene Rest Home's staff orientation programme is specific to the worker type and has been completed by all staff. A comprehensive training schedule is in place. A staffing policy is in place that includes a documented rationale for staffing the service. Staffing is designed to match the needs of the residents.

Outcome 1.3: Continuum of Service Delivery

The service has a documented assessment process and there is an information pack available for residents/families at entry. Care plans are individualised and evaluated six monthly. The service facilitates access to other medical and non-medical services. The activities coordinator and all staff provide a varied activity programme with residents actively engaged at all times and encouraged to access the community. Meals are prepared on site by the cook and individual and special dietary needs are catered for. Residents and family interviewed responded favourably to the food that was provided.

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.1.9: Communication	Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low			
HDS(C)S.2008	Criterion 1.1.9.1	Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Fourteen of 15 incident forms do not document that the family is informed after an incident and this is not routinely recorded in other parts of the resident file e.g. in the progress notes.	Document that family have been informed as appropriate after an incident.	180
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	(i) Satisfaction surveys are not collated to date. (ii) While there are internal audits, a schedule is not documented. (iii) The staff meeting minutes do not show a monthly review and discussion of all aspects of the quality programme and risk management programme.	i) Collate results of satisfaction surveys. ii) Document an internal audit schedule. iii) Ensure that all aspects of the quality and risk management programme are reviewed and discussed.	180
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	PA Low	Corrective action plans with evidence of resolution are not routinely documented where issues are	Ensure that there are corrective action plans with evidence of resolution documented.	180

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		implemented.		identified. The previous improvement required remains.		
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 Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	Two of the five resident files do not include the initial assessment, plan or first long term plan and these were unable to be located on the day of the audit noting that the registered nurse interviewed confirms that one of the two has been completed. ii) Four of five files do not include a signed agreement.	Ensure that the initial assessment, care plan and first long term care plan is completed in a timely manner and information retained in the resident file. ii) Ensure that all files include a signed agreement.	180
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	The care plans do not always include interventions for issues identified through the assessment process e.g.: a) one resident is documented as having with challenging behaviour however the care plan does not include strategies for staff to manage this, b) one file identifies the resident as having continence issues	Ensure that care plans document specific care and interventions required.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				however the care plan does not document interventions to manage this, c) one resident has a 4kg weight loss from August to December 2013 however a dietary profile is not documented.		
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Moderate	The care plan is not updated routinely when changes for the resident occur. Examples are as follows: a) one resident had a fracture in January 2014 however the care plan has not been updated to reflect the decrease in mobilisation of the resident following the fall, b) one care plan states that a resident walks independently in the community however the family and staff are concerned that this may now be 'wandering' without a purpose with three incident forms documented in January 2014 – all incident forms document that the resident knew where he was when asked.	Update the care plan as changes for the resident occur.	90
HDS(C)S.2008	Standard 1.3.12: Medicine	Consumers receive medicines in a safe and timely manner that	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Management	complies with current legislative requirements and safe practice guidelines.				
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	There are stock drugs held on site. ii) There are nurse initiated orders directing administration of specific medications. iii) Common bottles of oral medication are used for multiple residents. iv) The fridge that stores medication is not monitored.	i) Ensure that any medications are prescribed to a resident. ii) Ensure that only medications prescribed by the general practitioner or other designated health professional able to prescribe are administered. iii) Use individual bottles of oral medication are used for the resident for whom it is prescribed. iv) Ensure that the fridge that stores medication is at the correct temperature.	60
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	Hot food temperatures are not monitored. ii) There is no dietician review of the menu.	i) Monitor hot food temperatures to ensure that food is cooked through. ii) Provide a dietician review of the menu.	180

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: PA Low

Evidence:

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.
D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement through the agreement and in discussion with the manager or clinical nurse leader.
D16.4b Three of three relatives state that they are always informed when their family members health status changes.
The facility has an interpreter policy and procedures available for access to interpreter services and residents (and their family) are provided with this information at the point of entry. Interpreters are available through the DHB if required. There have been no residents who require interpreting services.
D11.3 The information pack is available in large print if required and advised that this can be read to residents.
Five of five residents and three of three family members interviewed state that there is excellent communication with the owner/manager, registered nurses and other staff.
All family members' state that they are informed when there is an incident.
One of 15 incident forms reviewed includes documentation that the family has been informed.
An improvement is required to ensure that all incident forms record that family are notified.

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: PA Low

Evidence:

Five of five residents and three of three family members interviewed state that there is excellent communication with the owner/manager, registered nurses and other staff.
All family members' state that they are informed when there is an incident.
One of 15 incident forms reviewed includes documentation that the family has been informed.

Finding:
Fourteen of 15 incident forms do not document that the family is informed after an incident and this is not routinely recorded in other parts of the resident file e.g. in the progress notes.
Corrective Action:
Document that family have been informed as appropriate after an incident.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA
Evidence:
The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. A complaints register is maintained and this is current with complaints documented for 2013. Two complaints were tracked for monitoring purposes to ensure that they are actioned according to timeframes in the policy and these identify that a complaint is resolved in a timely manner. These are documented on a register. D13.3h. A complaints procedure is provided to residents within the information pack at entry. Three of three family members and five of five residents interviewed confirm that they know how to make a complaint and all state that there is no reason for them to make a complaint but feel that any concerns would be resolved. The administration manager confirms that there have been no complaints with the Health and Disability Commissioner, Ministry of Health or the District Health Board since the last audit.

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:

Armourdene Rest Home provides care for up to 28 resident's rest home residents with 22 residents on the day of the audit.

The organisation has a written quality and risk management programme described as the leadership and management manual. Sections include governance, management, continuous quality improvement system and risk management. There are other manuals; a safe environment manual, an information management manual, which describes the control of critical documents and resident documents. There is a resident services manual, which describes the procedures for planned and appropriate services.

There is a mission statement documented which articulates a commitment to exceeding the expectations of residents, family and staff, supplying a quality service to residents and quality of life for as long as possible.

There are quality goals documented 2014-15 and these are reviewed annually at the management meeting with informal review completed during the year by the owner/manager.

The owner has owned the service for 10 years and has also owned a sister site for eight years. The owner/manager has a background in corporate management and is supported by a senior registered nurse who has a background in aged care nursing for over 15 years. There is also an administration manager who maintains quality systems.

The owner/manager and senior registered nurse have maintained at least eight hours annually of professional development activities related to managing a rest home.

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: <p>Armourdene Rest Home has a quality and risk management system that is overseen by the owner/manager, administration manager and senior registered nurse through informal discussions with the management team (notes kept by the owner/manager).</p> <p>Discussions with the senior registered nurse and the two caregivers and review of meeting minutes demonstrates staff involvement in quality and risk activities noting that the staff meetings do not have a set agenda and do not routinely include all aspects of the quality programme.</p> <p>There are monthly management meetings, monthly staff meetings, monthly cook's meetings and monthly activity staff meetings (both sites join for these meetings). Meeting minutes indicate that there is discussion around topics relevant to each meeting.</p> <p>Resident meetings are held monthly and facilitated by the activities coordinator. Minutes are documented. There are six monthly resident and relative surveys (last in June/July 2013). There are food satisfaction surveys also six monthly.</p> <p>D5.4 Service appropriate management systems, policies, and procedures are developed, implemented and reviewed for the sector standards and contractual requirements and the registered nurse /administration manager and others as required review these to align with standards. The quality and risk system is documented and links with associated policies/procedures. Clinical policies and procedures are in place for the rest home and are currently being reviewed.</p> <p>There is a document control process implemented that includes a review date and sign off by the administration manager.</p> <p>D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Health and safety is addressed through the staff monthly meetings at times. A hazard register is documented and hazard identification forms identify that any hazards are addressed in a timely manner and discussed at meetings.</p> <p>D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.</p> <p>D19.2g Falls prevention strategies such as lowering resident's beds, staff supervision and a review of any incidents around falls are implemented.</p> <p>There are implemented internal audits last completed in June/July 2013 and some audits identify corrective actions required with sign off of resolution in a timely manner. The improvement required at the previous audit around corrective actions and evidence of resolution continues to require addressing.</p>

Further improvement is required to the quality programme including collation of data from satisfaction surveys, documentation of an internal audit schedule and discussion of all aspects of the quality programme and risk management programme through the staff meeting.

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

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

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: PA Low
Evidence: Quality data is collected through six monthly internal audits, complaints, incidents accidents and satisfaction surveys. The last audits were completed in June/July 2013.

Finding:
(i) Satisfaction surveys are not collated to date. (ii) While there are internal audits, a schedule is not documented. (iii) The staff meeting minutes do not show a monthly review and discussion of all aspects of the quality programme and risk management programme.
Corrective Action:
i) Collate results of satisfaction surveys. ii) Document an internal audit schedule. iii) Ensure that all aspects of the quality and risk management programme are reviewed and discussed.
Timeframe (days): 180 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

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

Attainment and Risk: PA Low
Evidence:
There are issues identified through satisfaction surveys, audits, meetings and corrective action plans with evidence of resolution are documented for some areas where issues are identified e.g. sign off of actions in some resident meeting minutes on a corrective action plan.
Finding:
Corrective action plans with evidence of resolution are not routinely documented where issues are identified. The previous improvement required remains.
Corrective Action:
Ensure that there are corrective action plans with evidence of resolution documented.
Timeframe (days): 180 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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: D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service identifies that the following situations would be reported to statutory authorities: infectious diseases; serious accidents to the Department of Labour; unexpected death; specific situations to the MoH. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. Meeting minutes from the staff meetings do not reflect discussion of incidents and accidents (refer 1.2.3.6). A review of incident/accident forms for Armourdene Rest Home (15 reviewed) identifies that all incident forms include follow-up actions taken. The senior registered nurse has reviewed these with graphs of the results for each month completed. Data is reviewed to look at trends (refer 1.2.3).

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: Five staff files were reviewed including the clinical nurse leader, one registered nurse and three caregivers. D17.7d: There are implemented medication competencies for all relevant caregivers and registered nurses around medication and evidence in staff files confirms that

these have been completed for relevant staff.

Current practicing certificates are sighted for the registered nurses, doctors, dietician and physiotherapist.

Five of five staff files include a signed contract, application form, evidence of training, referee checks, police checks and job description.

Five of five files reviewed indicate that staff have completed an orientation programme that is relevant to support for people using rest home level care with the service having a low turnover rate.

The owner/manager and registered nurse confirm that they have completed at least eight hours training a year (training records sighted for the registered nurse).

Five of five residents interviewed and three of three family members interviewed state consistently that staff are competent, caring and knowledgeable.

There is an annual training plan and two caregivers confirm that they find the training valuable.

The previous improvement required around orientation has been 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): <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>Staff levels and skill mixes are appropriate for the service of this type. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There are 27 staff employed in the service.</p>

The service contracts with allied health professionals on an as required basis.

Staffing is as follows (22 of 28 residents):

AM: Two caregivers from 7.30am-4pm.

PM: Two caregivers 4pm to 12pm.

Night: Two caregivers from 12pm to 7.30am.

The service shares the two registered nurses and one enrolled nurse with the sister site and staff confirm that there is a registered nurse on site for 40 hours a week, five days a week and on call 24 hours a day.

Five of five residents interviewed report there are always enough staff on duty and all praised the staff for the care and support provided.

Staff turnover is low.

The owner/manager attends each site during the week and is available in the weekends.

The improvement required at the previous audit around a staff member with a first aid certificate on each shift has been addressed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Records have been integrated with each resident having their own file. Medication records are kept with the medication and this is appropriate to the service.

The improvement required at the previous audit around integration of records has been addressed.

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

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: PA Moderate
Evidence: D16.2, 3, A registered nurse completes the assessment on admission, with the initial care plan completed within 24 hours of admission in three of the five files reviewed. Within three weeks, the long term care plan is developed as evidenced in four resident files sampled. One of five files reviewed includes a signed agreement. The owner/manager states that one of the other four agreements is still with family. This is an area requiring improvement. There is evidence of resident and/or family/EPOA involvement in the care planning process. The activities coordinator completes an activities assessment involving the resident and their family soon after admission. An activity plan is developed. Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs. A range of assessment tools available for use on admission includes a) dietary profile b) pressure area risk assessment, c) continence assessment d) falls risk assessment e) pain assessment and g) challenging behaviour assessment. A dietary profile is completed in three of four files reviewed (link1.3.6.1). There is a verbal handover for caregivers at the beginning of each shift. Any resident concerns or events are communicated to the oncoming staff. Caregivers can describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. The afternoon shift handover is observed. All four files identified integration of allied health including the general practitioner. Medical assessments are completed within 48 hours of admission in four of four resident files sampled. The general practitioner completes routine three month visits and

medication reviews or more frequently as documented and required. The general practitioner states that there is 'good quality of care' and confirms that the general practitioner is informed if there are significant issues noting that minor issues or changes are managed within the ability of the registered nurses. The general practitioner states that there is good follow up following the visit and confirms that caregivers 'provide good hands on care'. The general practitioner states that the registered nurses and caregivers 'take their work seriously'.

Tracer methodology;

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

An improvement is required to documentation of initial assessments, care plans and agreements.

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: Three of five initial assessments, initial care plans and initial long term plan are in the resident file and documentation indicates that these are completed on the day of admission or within 24-hours for the initial assessments and plans and within three weeks for the long term care plan. One of five files includes a signed agreement.
Finding: Two of the five resident files do not include the initial assessment, plan or first long term plan and these were unable to be located on the day of the audit noting that the registered nurse interviewed confirms that one of the two has been completed. ii) Four of five files do not include a signed agreement.

Corrective Action:

Ensure that the initial assessment, care plan and first long term care plan is completed in a timely manner and information retained in the resident file. ii) Ensure that all files include a signed agreement.

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Residents' support plans are completed by the registered nurse. When a resident's condition alters, the registered nurses initiate a review and if required, general practitioner or specialist consultation. The general practitioner confirms that the general practitioner is notified when required.

The two caregivers and registered nurse interviewed stated that they have all the equipment referred to in support plans necessary to provide care, including chair scales that they share with the sister site, continence products that are individualised, two pressure area mattresses, lifting belts, wheelchairs, gloves, aprons and masks. The service has access to physiotherapy services for equipment assessment and advice.

D18.3 and 4 Dressing supplies are available and the treatment room is well stocked. Staff report that there are adequate dressing supplies. There are no residents currently with wounds.

Wound care plans can be described for minor skin tears and wounds.

Dietary profile forms that include specific dietary requirement, likes and dislikes are completed on admission for all new admissions. Dietary profiles are reviewed six monthly. Copies are sent to the cook. The cook confirms dietary profiles and any special requests are received from the registered nurse. The cook is aware of any residents with weight loss and a high calorie diet is provided as described for one resident. All residents are weighed monthly and more frequently if there is a need for weight monitoring. The general practitioner confirms that the doctor reviews residents weight loss at the three monthly review or earlier if notified of weight loss by the

registered nurse. The podiatrist visits six weekly.
There is an improvement required to documentation of interventions.

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:

There is a challenging behaviour policy that describes the use of a behavioural assessment and behaviour monitoring form. One resident has an assessment that identifies challenging behaviour and staff describing refusal of cares particularly in the morning. The care plan refers to the challenging behaviour and staff describe interventions and strategies to manage this.

The assessment for one resident identifies an issue around continence with strategies observed to be in place and described by staff to be in place to manage this. A dietary profile is completed in three of four files reviewed with information used to document strategies and interventions.

Finding:

The care plans do not always include interventions for issues identified through the assessment process e.g.: a) one resident is documented as having with challenging behaviour however the care plan does not include strategies for staff to manage this, b) one file identifies the resident as having continence issues however the care plan does not document interventions to manage this, c) one resident has a 4kg weight loss from August to December 2013 however a dietary profile is not documented.

Corrective Action:

Ensure that care plans document specific care and interventions required.

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 service employ an activities coordinator for two days a week currently. The previous activities coordinator was providing a five day (40 hours a week) service however; the service is currently recruiting a staff member given the resignation of the previous activities coordinator a month ago. The activities coordinator from the sister site is actively involved in the service during this time.

The activities coordinator documents a programme that focuses on recreational, spiritual, cultural, physical and cognitive abilities.

There is one client from a local association who visits during the week to participate in activities.

There are van rides during the week and residents join with others from the sister site.

The activities coordinator completes an activity assessment as soon as practical after admission of a new resident and develops an activity care plan with resident and family involvement. The care plan is reviewed six monthly. Attendance sheets are maintained for each resident. Progress notes are written monthly or when significant events occur into the integrated file.

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

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 Moderate
Evidence: The registered nurse completes a review of the long term care plan six monthly. Changes to health status are sometimes included on the care plan. The service uses short term care plans to document specific care e.g. there is one resident who has a short term care plan for pain with resident having sustained a fracture in January 2014. The general practitioner reviews the resident three monthly and reviews the residents weight, blood pressure and pulse and any concerns the registered nurse or resident/family wish to discuss. D16.4a Care plans are evaluated six monthly more frequently when clinically indicated. An improvement is required to updating of the care plan as changes occur.

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

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: PA Moderate
Evidence: At times in the five files reviewed, there is evidence that the care plan is updated as changes occur.
Finding: The care plan is not updated routinely when changes for the resident occur. Examples are as follows: a) one resident had a fracture in January 2014 however the care plan has not been updated to reflect the decrease in mobilisation of the resident following the fall, b) one care plan states that a resident walks independently in the community however the family and staff are concerned that this may now be 'wandering' without a purpose with three incident forms documented in January 2014 – all incident forms document that the resident knew where he was when asked.
Corrective Action: Update the care plan as changes for the resident occur.
Timeframe (days): 90 <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 policies and procedures in place for all aspects of medicine management. These comply with the current safe practice guidelines. During the audit a medication round was observed and practice was seen to be safe and according to the policies and procedures. The caregiver completing the medication round is able to describe the process as per the policy. A robotic system is in place and medicines are supplied by a local pharmacy. PRN medications are supplied in blister packs. On arrival from the pharmacy, the registered nurse checks medicines against the prescription chart – sighted. There is a medication fridge and the temperature is checked and recorded weekly. There is a controlled drug safe, which complies with the drug regulations. The controlled drug register was verified as accurate with a check of controlled drug balances.

Medicines are stored securely in a locked cupboard and trolley, which is supervised by the caregiver when administering medication. The keys are held on the person of the caregiver or registered nurse.

Allergies are recorded on the prescription charts and in the clinical files. Any errors are reported via the incident accident reporting system. Review of medication errors show that there are few errors and these are always investigated and followed up by the registered nurse.

Caregivers are trained by the registered nurse in medication administration procedures. Before they are able to administer medicines, they are required to sit a competency test and this is completed annually for all caregivers, registered nurses and the enrolled nurse.

A total of ten medication prescription and administration records were sighted. All comply with the requirements. Specimen signatures are recorded. There is a policy and procedure in place for the safe self-administration of medicines, however at this time no residents self-administer medication.

Improvements are required to the medication system including use of stock drugs, nurse initiated orders, use of common bottles of oral medicines and ensuring that the fridge that stores medication is at the correct temperature.

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: There are policies and procedures to guide medication administration. Medications are held in a locked cupboard. There are prescriptions for medications for each resident.
Finding: There are stock drugs held on site. ii) There are nurse initiated orders directing administration of specific medications. iii) Common bottles of oral medication are used for multiple residents. iv) The fridge that stores medication is not monitored.
Corrective Action: i) Ensure that any medications are prescribed to a resident. ii) Ensure that only medications prescribed by the general practitioner or other designated health professional able to prescribe are administered. iii) Use individual bottles of oral medication are used for the resident for whom it is prescribed. iv) Ensure that the fridge that stores medication is at the correct temperature.
Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <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:

Fluids are provided with each meal, jugs of water are available in residents` rooms and morning tea, afternoon tea and supper is provided. Any dietary requirements are identified on admission by the registered nurse and the cook is familiar with dietary needs (refer 1.3.6.1). The cook interviewed explained that the kitchen staff can cater for all dietary requirements and there are instructions related to what plate to use, if food should be cut up, and the type and portion size of the meal. The kitchen is clean and has cooking appliances for the numbers to be catered for. All food supplies are delivered on a regular basis to meet the menu requirements. Food is stored safely, labelled with contents and expiry dates are monitored. There are daily temperature recordings of the freezers and chiller and food temperatures are recorded with documentation indicating that all food temperatures are in the correct range. All kitchen staff have attended food safety training and completed the necessary requirements. Three of three family members interviewed confirmed that the food meets the approval of their family member from their observation and residents appeared to enjoy the meal at lunchtime. Five of five residents state that they enjoy the meals. Meals on the day of the audit are appetising and hot. An improvement is required to review of the menu by the dietician and to monitoring of hot food temperatures.

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:

There are policies around food services.
Fridge and freezer temperatures in the kitchen are checked.

Finding:

Hot food temperatures are not monitored. ii) There is no dietician review of the menu.

Corrective Action:

i) Monitor hot food temperatures to ensure that food is cooked through. ii) Provide a dietician review of the menu.

Timeframe (days): 180 (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: FA

Evidence:

The facility has a current building warrant of fitness that expires 1 December 2014.

There is a reactive and planned maintenance system and the owner/manager was observed to attend to repairs on the day of the audit.

Residents are observed moving freely about the home and accessing the communal areas with ease.

ARC D15.3; There is adequate equipment available for the rest home including a pressure area mattresses, lifting belts, wheelchairs, mobility aids, chair scales shared with the sister site.

Equipment has been calibrated in July 2013.

While the facility is an older one, the family members and residents state that it is like a 'family home' and they enjoy living in it.

The site is safe both inside and out with rails appropriately placed to support residents.

There are deck areas outside for residents to use. Surfaces were checked on the day of the audit (given that they were wet) to ensure that they were not slippery and all ramps and decks have a rough surface to stop residents slipping.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

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

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

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

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 policy around restraint and enablers is applicable to the type and size of the service (rest home).
The service has a restraint free philosophy.
Restraint is not used and there are currently no enablers used.
The policies and procedures are comprehensive, including definitions, processes and use of enablers.
The policy includes that enablers are voluntary and the least restrictive option.
Strategies are in place to minimise the use of restraint including mobility aids and supervision of residents.
Two caregivers and the registered nurse interviewed confirm knowledge of restraint, enablers and management of challenging behaviours.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The infection control surveillance policy describes the surveillance programme. The staff meeting (infection control meeting) includes discussion of infection control and discussion of the monthly data.

All infections are collected via the infection report form. There is a collated report of infections monthly including site and use of antibiotics and a graph generated. Trends and individual outcomes are noted and acted upon by the registered nurse as stated by the registered nurse. Surveillance methods and processes including individual infection reports adequately identify the risk factors and needs of the residents.

The infection control coordinator is the registered nurse.

Staff interviewed including the two caregivers confirm knowledge of best infection control practice and of surveillance data.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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