

# Aroha Care Centre for the Elderly

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Current Status: 24 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

Aroha Care Centre provides hospital and rest home level care for up to 71 residents. The service is in the process of completing renovations and currently has 36 rest home level beds, and 35 hospital level beds.

Aroha Care Centre is governed by a Trust Board and managed by a principal nurse manager. The manager has extensive management experience in aged care. She is supported by a clinical nurse manager, registered nurse/quality officer and rest home charge nurse.

There is an implemented quality process and training plan. Resident and family interviewed included positive feedback about the service and care provided.

The previous audit identified seven areas for improvement around the quality process, family involvement, aspects of care planning documentation, medication management, chemical storage and restraint monitoring. Six of seven shortfalls have been addressed, with one shortfall around management of challenging behaviour remaining an area for improvement. This audit has identified three further areas requiring improvement around; use of short-term care plans, timeliness of care plan documentation ensuring care plans are up to date and signing of medications.

## Audit Summary as at 24 February 2014

Standards have been assessed and summarised below:

### Key

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

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

### Consumer Rights as at 24 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 24 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 24 February 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 24 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 24 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 24 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>Standards applicable to this service fully attained.</p>
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# HealthCERT Aged Residential Care Audit Report (version 4.0)

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## 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

<b>Legal entity name:</b>	Aroha Care Centre for the Elderly		
<b>Certificate name:</b>	Aroha Care Centre for the Elderly		
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited		
<b>Types of audit:</b>	Surveillance Audit		
<b>Premises audited:</b>	Aroha Care Centre for the Elderly		
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)		
<b>Dates of audit:</b>	<b>Start date:</b> 24 February 2014	<b>End date:</b> 25 February 2014	
<b>Proposed changes to current services (if any):</b>			
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>			69

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	6
<b>Other Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	12	Total audit hours off site	8	Total audit hours	20
Number of residents interviewed	8	Number of staff interviewed	9	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	26	Number of relatives interviewed	4
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

## Declaration

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

I confirm that:

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

Dated Friday, 28 March 2014

## Executive Summary of Audit

### General Overview

Aroha Care Centre provides hospital and rest home level care for up to 71 residents. The service is in the process of completing renovations and currently has 36 rest home level beds, and 35 hospital level beds. Occupancy during the audit was 34 residents at rest home level and 37 at hospital level. Aroha Care Centre is governed by a Trust Board and managed by a principal nurse manager. The manager has extensive management experience in aged care. She is supported by a clinical nurse manager, registered nurse/quality officer and rest home charge nurse. There is an implemented quality process and training plan. Resident and family interviewed included positive feedback about the service and care provided. The previous audit identified seven areas for improvement around the quality process, family involvement, aspects of care planning documentation, medication management, chemical storage and restraint monitoring. Six of seven shortfalls have been addressed, with one shortfall around management of challenging behaviour remaining an area for improvement. This audit has identified three further areas requiring improvement around; use of short-term care plans, timeliness of care plan documentation ensuring care plans are up to date and signing of medications.

### Outcome 1.1: Consumer Rights

Incident and accident policies include open disclosure policy. Family are involved in the initial care planning and receive and provide on-going feedback. Regular contact is maintained with family including if an incident/ accident or a change in residents health status occurs. The service has documented complaints and there is evidence of follow up. The complaints register reviewed included verbal and written complaints. Family meetings are documented with resident meetings documenting that the results of the family survey were discussed. There is a policy that describes the availability of interpreter services when required.

### Outcome 1.2: Organisational Management

Aroha Care Centre has a quality framework that is being implemented. The principle nurse manager is directly involved in operations at the facility and the clinical nurse manager supports her in this role. There is a current quality plan that includes goals and a quality assurance plan, which includes internal audit, incident collation, infection surveillance and hazard management. Interview with staff confirm an understanding of the quality activities undertaken at Aroha. The previous audit found that not all corrective action plans were documented as implemented. This audit evidences that action plans have been followed up and signed off. Resident meetings ensure that residents are informed of service changes. Annual surveys are conducted of residents and relatives. All residents and relatives interviewed stated they are asked for feedback regarding the service. This service has implemented a 'No harm from falls' project as part of quality improvement. Aroha has been proactive with the implementation of InterRAI, there are eight registered nurses now assessed as interRAI competent. All hospital residents are now transferred onto the interRAI system and the rest home is in the process. The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All residents and family members interviewed stated that they felt there was sufficient staffing. There is an implemented training policy and schedule and attendance recorded at sessions kept, there is at least eight hours annually of training provided.

### **Outcome 1.3: Continuum of Service Delivery**

Residents' care plans are individualised for each resident. Residents' clinical notes are integrated to ensure service delivery reflects continuity of care, including input from all providers involved. There are policies and procedures in place to guide the staff around assessment, care planning evaluation and review. Discussions with the clinical coordinator confirmed registered nurse attendance at regular DHB education sessions. Assessment, planning, evaluation, review and exit are undertaken by the registered nurses with input from allied health professionals and caregivers. This audit has identified areas for improvement around timeliness of care planning documentation of challenging behaviour management, documentation that care interventions are undertaken as planned and reassessment and care planning of resident following acute illnesses.

There is an activities programme that operates formally over seven days, which offers a variety of activities suited to the needs of the residents.

Medicine is administered via the robotic sachet dispensing system. Staff that dispense medicines have been assessed as competent.

There is an improvement required around aspects of medication documentation.

Residents' nutritional needs are assessed on admission and likes, dislikes and allergies are communicated to the kitchen staff at admission. The menu was reviewed by a dietitian.

### **Outcome 1.4: Safe and Appropriate Environment**

The building is purpose built. There is current building warrant of fitness and reactive and preventative maintenance schedules are implemented. Chemicals are safely stored and this is an improvement on previous audit.

### **Outcome 2: Restraint Minimisation and Safe Practice**

There is a restraint policy There is a restraint manual applicable to the type and size of the service. The restraint manual includes a section on training that covers policies, procedures, challenging behaviours management, de-escalation techniques, emergency / acute restraint and appropriate use of safety enablers. Restraint training occurs yearly, challenging behaviour training has been provided. Staff were familiar with the policy and the definition of enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and use of enablers.

The restraint manual determines that enablers are voluntary and the least restrictive option. There are no enablers in use in the facility and eight residents with restraints. Monitoring forms were completed and this is an improvement on previous audit.

### **Outcome 3: Infection Prevention and Control**

The infection control coordinator is a registered nurse. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly, the infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
<b>Standards</b>	0	16	0	1	2	0	0
<b>Criteria</b>	0	41	0	1	2	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
<b>Standards</b>	0	0	0	0	0	0	0	31
<b>Criteria</b>	0	0	0	0	0	0	0	57

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
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 Low	Of the three rest home level resident files reviewed, two did not have a long term care plan documented within three weeks. One rest home resident for whom pain was a documented problem did not have a pain assessment documented and one rest home resident who had been admitted to hospital	Ensure that care plans are documented and in place within three weeks and assessments and care plans are updated as the resident need changes	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				and transferred back to the service did not have documented re-assessments in place although the resident's condition had changed.		
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	<p>In the rest home, one resident file did not document the specific care need to manage a resident with behaviours that challenge. This remains a finding from the previous audit. One resident did not have a short term care plan in place for a resident with an infection.</p> <p>In the hospital, one resident with restraint had restraint documented in the care plan but not the risks associated with the restraint, and one resident who had documented weight loss did not have this reflected in the care plan and weekly weights as requested by the GP were not in</p>	Ensure that care plans reflect the resident need, including the risks associated with care interventions. Short term care plans should be in place for acute problems and weights should be documented as undertaken as per instruction.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				place.		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	For the hospital and rest home, medication charts do not document indications for use with PRN medications. One of six medication charts do not have all medications signed for on administration in the rest home. In the hospital, three of six medication administration charts did not have all non-packaged regular medications signed for.	Ensure that all medications are signed for on administration and ensure that PRN medications have indications for use documented.	30

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

#### Evidence:

There are policies that include; Incidents and accidents, and complaints, which include process around open disclosure. Open disclosure includes the responsibility of staff to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs.

As part of the six files reviewed (three hospital and three rest home), seven incident forms were reviewed. All seven-incident forms included family information regarding the incident. Progress notes also include family communication.

On interview eight residents (four hospital and four rest home), four family members (three hospital and one rest home), four caregivers and two registered nurses all stated that family are informed following changes in the residents' health status.

The resident files document regular MDT meetings; new residents within one month and then six monthly, that include family involvement or family information

Family meeting are documented with October's meeting documenting that the results of the family survey were discussed.

There is a policy that describes the availability of interpreter services when required.

D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry

D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b: Four family members stated that they are always informed when their family members health status changes.

D11.3: The information pack is available in large print and advised that this can be read to residents.

### 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:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with four hospital and four rest home residents inform an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints</p> <p>There is a complaints register that includes all complaints. Complaints for 2014 were reviewed. There are three documented complaints; all are more typical of the complainant asking for information regarding the service or about resident care. All three document that the service has responded in full, Four family members (one rest home and three hospital) and confirmed that any issues are addressed and they feel comfortable to bring up any concerns. Discussions with four care givers ( two rest home and two hospital) and a review of meeting minutes confirms that that concerns/complaints were discussed at monthly quality meetings.</p> <p>D13.3h: A complaints procedure is provided to residents within the information pack at entry.</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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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:

Aroha is certified to provide hospital (Geriatric) and rest home level care. The service is completing renovations and currently has 36 rest home level beds, 35 hospital level beds including ten swing beds. On the day of audit, the occupancy includes; 32 residents at rest home level and 37 at hospital level.

Aroha Care Centre is governed by a Trust Board who meets quarterly. The service is managed by a principal nurse manager has extensive experience in Aged Care (24 years) and 14 years in management positions. She has been in post for six years. She is supported by a clinical nurse manager, registered nurse/quality officer and rest home charge nurse. Weekly visits from board members and quarterly board meetings ensure that there is good communication between the board and local governance.

There is a documented quality plan for 2014; the quality plan includes a review of the 2013 objectives and specific objectives for 2014. Objectives include both quality objectives including (but not limited to); the implementation of robotics medication system, a reduction in falls and facility upgrade) and business objectives.

The documented and implemented quality process include health and safety meetings, care staff meetings (which included care related agenda items), staff meetings, monthly quality meetings and falls prevention meetings.

All meetings are documented and evidence that the flow of information between staff, management and the board is appropriate.

ARC, D17.3di The manager and clinical nurse manager have maintained at least eight hours annually of professional development activities related to managing a hospital and 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.

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

### 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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>  <p>Aroha Care Centre has an implemented quality framework. The principle nurse manager is directly involved in operations at the facility and the clinical nurse managers supports her in this role. There is a current quality plan that includes goals and a quality assurance plan, which includes internal audit, incident collation, infection surveillance and hazard management. Interview with all staff (two rest home and two hospital caregivers, the activities coordinator, two registered nurses and the quality person/ senior nurse) inform an understanding of the quality activities undertaken at Aroha. Resident meetings reviewed for October and document that resident are informed of service changes, the outcome of the October resident survey is documented and resident feedback is elicited. Four hospital and four rest home residents interviewed are aware meetings are held. Annual surveys are conducted of residents and relatives. All residents and relatives interviewed stated they are asked for feedback regarding the service. At the time of audit resident and relative feedback indicated satisfaction with the service. Of note for this service is the 'No harm from falls' project. This project was implemented in response to an analysis of the 2013 skin tear outcomes. The service commenced additional training for staff and have linked to the DHB with this project. The project has included skin care training, reviews of moving and handling of resident, physio review of transferring aids, teamwork promotion and staff allocations to ensure less experienced staff work with experienced staff. The project has also included; Tags to resident frames for residents who are assessed as high falls risk (This is to alert staff to the risk). The staff room has a calendar, which identifies where falls are on a day-to-day basis, audits of nurse call attendance, and the vitamin D programme for all residents. The 'no harm from falls' project has documented meetings where the project plan and outcomes are discussed. There are also monthly reviews of falls and skin tears. Aroha has been proactive with the implementation of InterRAI, there are eight registered nurses now assessed as interRAI competent. All hospital</p>

residents are now transferred onto the interRAI system and the rest home is in the process.

D5.4: The service has policies/ procedures to support service delivery.

D10.1: Care of the deceased resident procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.

D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.

D19.2g: Falls prevention strategies include a very proactive falls prevention process, which the service is commented for

Policies and procedures are reviewed every two years, additional expertise is consulted as needed. There are comprehensive policies in place appropriate to rest home and hospital level care. Policy and procedure documents no longer relevant to the service are removed and archived.

Meetings discuss key components and standing agenda items of the programme include audit, infection, incidents, complaints and health and safety.

Documentation is archived in a locked facility.

Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. There is a separate incident form in use for falls.

Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete. Restraint and enabler usage is documented.

There is a documented internal audit programme aligned to the QPS system plus additional audits that are service based. Audits reviewed all document an action plan as needed. Monitoring data that is collected by way of monthly: incident report, infection collation, and outcomes from internal audits are reported through to quality/health and safety and staff meetings.

Accident and incidents monthly summary and infection control monthly summary forms include preventative actions identified and implementation.

The previous audit found that not all corrective action plans were documented as implemented. This audit evidences that action plans have been followed up and signed off.

### **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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There is a policy that describes accident/incident management. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality risk management system. Once incidents and accidents are reported, the immediate actions taken are documented in incident forms. Each month incidents and accidents are reviewed, collated and a report generated. The report includes both the current month's incident and accident statistics and any changes from the previous month. There is a monthly action plan for falls, skin tears and bruises, medication errors, resident behaviour, ant staff related incidents and hazards. This comprehensive report links to QPS benchmarking and staff / quality meetings. Seven incidents and accident forms reviewed all document that the service is proactive with registered nurse review of the incident and following up with any problems identified. Actions are reflected in residents long term care plans (LTCP). If risks are identified these are also processed as hazards. 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.

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Six staff files were reviewed; one housekeeper, three caregivers and two registered nurses. All six files include contract for employment, reference checks and police checks prior to employment, a relevant job description and evidence of an orientation on employment. Three files included annual appraisals and three files were for new staff.</p> <p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities.</p> <p>The practising certificates of RN's are current. The service also maintains copies of other visiting practitioner's certification including GP, pharmacist and physiotherapist. The service has documented training/induction process that describes the management of orientation. Newly appointed staff complete an orientation that was sighted in all files reviewed.</p> <p>Interviews with four caregivers described the orientation programme that includes a period of supervision.</p> <p>The service has a training policy and schedule for in-service education. The in service schedule is implemented and attendance recorded at sessions kept. There is at least eight hours annually of training provided. Medication competencies are completed for all RN's and the caregivers who administer medication.</p> <p>D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); medication.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. All residents and family members interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the manager and the clinical coordinator will be on-call at all times, that at least one staff member on duty will hold a current first aid qualification. Residents and relatives interviewed stated they felt there was sufficient staff to meet the needs of residents.

The roster includes the principle nurse manager on duty Monday to Friday, a senior registered nurse on duty seven days a week plus and a registered nurse on duty every shift. There are caregivers for all areas all shifts.

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> <p>There are policies and procedures in place to guide the staff around assessment, care planning evaluation and review. Discussions with the clinical coordinator confirmed registered nurse attendance at regular DHB education sessions.</p> <p>Assessment, planning, evaluation, review and exit are undertaken by the registered nurses with input from allied health professionals and caregivers as sighted in three rest home and three hospital residents files sampled. Service delivery is primarily undertaken by caregivers under the guidance of the registered nurses as evidenced in resident progress notes.</p> <p>The service is in the process of changing over to a new care plan template and this is aligned to residents who have been assessed using the interRAI process.</p> <p>In the hospitals, the GP provides two GP rounds a week and all hospital level residents have at least a monthly GP review. The rest home has four visiting GPs and three resident files reviewed all document GP review at least three monthly.</p> <p>One GP interviewed was very complementary about the service and the level of care provided and expresses a high level of confidence in the service and reports that the registered nurses contact him by telephone or fax at appropriate times.</p> <p>D16.2, 3, 4: Three hospital files were reviewed and all files identified that an assessment and initial care plan were completed within 24 hours and a long-term care plan</p>

completed within three weeks. The care plan is reviewed by the registered nurses and amended when current health changes. In the rest home; two of three resident files did not have the LTCP within three weeks and one care plan did not document a re-assessment of need (and subsequent care plan update) following a hospital admission.

D16.5e; All six resident files reviewed identified that the GP had seen the resident within two working days.

All 12 resident medicine records sampled show that the medicines have been reviewed three monthly. Doctors' visits and allied health notes (physiotherapist, dietitian, podiatrist etc.) are included in resident files. Assessment/monitoring forms such as continence monitoring, risk of falls, risk of pressure areas and pain management are available also wound management and monitoring.

There is a handover between shifts. Caregivers and registered nurses interviewed were able to describe the handover process. Six care plans reviewed documented family and / or resident involvement. This is an improvement on the previous audit

Tracer Methodology: Rest home

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

Tracer methodology; Hospital

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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.

<b>Attainment and Risk:</b> PA Low
<p><b>Evidence:</b></p> <p>Six resident files were reviewed, three rest home and three hospital level care. In the hospital, all three resident files documented an assessment completed within 24 hours and the long-term care plan was completed within three weeks. The care plans reviewed evidence evaluation by a registered nurse and are amended when current health changes. Six of six care plans evidenced evaluations completed at least six monthly.</p> <p>In the rest home, all three resident files document an assessment and initial care plan within 24 hours, and one of three care plans document a long term care plan within three weeks. Pain assessments are in place for two of three residents and for two of the three resident files the service has updated assessments and care plans with a change on resident need.</p> <p>In the hospital, all three resident files document an assessment and initial care plan within 24 hours, and all three care plans document a long term care plan within three weeks, assessments and care plans are updated with a change on resident need.</p> <p>All six resident files reviewed identify that the general practitioner has seen the resident within two working days of admission.</p>
<p><b>Finding:</b></p> <p>Of the three rest home level resident files reviewed, two did not have a long term care plan documented within three weeks. One rest home resident for whom pain was a documented problem did not have a pain assessment documented and one rest home resident who had been admitted to hospital and transferred back to the service did not have documented re- assessments in place although the resident's condition had changed.</p>
<p><b>Corrective Action:</b></p> <p>Ensure that care plans are documented and in place within three weeks and assessments and care plans are updated as the resident need changes</p>
<p><b>Timeframe (days):</b> 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

**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.

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

### Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

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

**Attainment and Risk:** FA

**Evidence:**

The previous audit had a finding around documentation of wound assessments and documentation of behaviour monitoring forms. All wound care plans reviewed (ten hospital and five rest home) all have a documented assessment. One resident with challenging behaviour has a behaviour monitoring form. This is an improvement on the previous audit (also link 1.3.3.3).

### Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

**Attainment and Risk:** 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:**

Aroha Care Centre provides services for residents requiring rest home and hospital level of care. The care being provided is consistent with the needs of residents; this is evidenced through interviews with caregiver's families, registered nurses, residents and two managers.

Residents' long term care plans are completed by the registered nurses. The service is currently moving to a new care plan format in association with introduction of the interRAI assessment process.

Staff interviewed state that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, continence supplies, dressing

supplies and any miscellaneous items. Staff state that when something that is needed is not available, management provide this promptly. All staff report that there are always adequate continence supplies and dressing supplies. On the day of the audit, plentiful supplies of these products were sighted. The residents and family members interviewed were complimentary of care received at the facility.

All clinical staff has access to residents' care plans and progress notes. The residents interviewed and four family members interviewed report staff are respectful and that their privacy and individuality is maintained.

The staff education schedule was sighted for 2013 and demonstrates that staff receive appropriate training. Staff were observed to be respectful in residents' care delivery on the days of the audit.

Six resident files reviewed, three rest home and three hospital,

Medical conditions are and care is included in care plans, this is an improvement on the previous audit.

In the rest home, files reviewed included high fall risk residents a new resident, and a resident with challenging behaviour. Activities of daily living are documented well in care plans. Falls risks are addressed. (Link also to 1.3.3.3 for post admission assessments and care plans and timeframes for LTCPs).

One resident with challenging behaviour had well documented triggers and warnings in the care plan but management of behaviour was not documented, One resident with an infection did not have a STCP n place. This is identified as an area for improvement.

In the Hospital: Three files reviewed included a resident with behaviour that challenges, fall resident, resident with wound a resident with weight loss and a resident with restraint, a pressure sore and pain control. As with the rest home, care plans document activities of daily living well. Falls risks are addressed as are wound care plans including the management of pressure areas. Documentation of the risks associated with restraint, and documentation of resident weights according to the GP instruction are areas for improvement.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.

Specialist continence advice is available as needed and this could be described.

Continence management in-services and wound management in-service have been provided.

The hospital has ten wounds documented, six of which are low grade pressure areas. All wounds are documented well including assessments, management plans and documented evaluations.

The rest home has five wounds documented three of which are healed pressure areas that the service monitors. All wounds are documented well including assessments, management plans and documented evaluations.

### **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:**

Aroha provides services for residents requiring rest home and level of care. The care being provided is consistent with the needs of residents; this is evidenced through interviews with caregivers, relatives, two registered nurses and four hospital and four rest home residents.

Discussion with roistered nurses and caregivers evidenced that they are knowledgeable regarding the care needs of individual residents.

Residents' long term care plans are completed by the registered nurses. The four caregivers and two registered nurses interviewed state that they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, continence supplies, dressing supplies and any miscellaneous items. The four residents interviewed and four family members interviewed were complimentary of care received at the facility.

All clinical staff have access to residents' care plans and progress notes.

**Finding:**

In the rest home, one resident file did not document the specific care need to manage a resident with behaviours that challenge. This remains a finding from the previous audit. One resident did not have a short term care plan in place for a resident with an infection.

In the hospital, one resident with restraint had restraint documented in the care plan but not the risks associated with the restraint, and one resident who had documented weight loss did not have this reflected in the care plan and weekly weights as requested by the GP were not in place.

**Corrective Action:**

Ensure that care plans reflect the resident need, including the risks associated with care interventions. Short term care plans should be in place for acute problems and weights should be documented as undertaken as per instruction.

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

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

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

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

**Attainment and Risk:** FA**Evidence:**

The service employs four activities staff (2 staff have a diversional therapy qualification). An occupational therapist is employed 3 hours per week who interacts with the staff to provide activities to the rest home and hospital residents over five days a week.

Weekly activities programmes are planned on monthly basis and there is a programme running each. The activities provided are in keeping with the strengths, interests and needs identified in each resident/s activities plan and include group activities and 1:1 activities for residents who have needs, which cannot be met in a group setting. A copy of the monthly planner is displayed on notice boards to advise staff and residents of the activities that are occurring. Residents interviewed are satisfied with the programme. Residents are able to provide feedback and suggestions for activities at the resident meetings, which are held two monthly. Minutes of residents' meeting were sighted. Results of the resident satisfaction survey completed in 2013 record positive outcomes. The four hospital and four rest home residents interviewed and three hospital and one rest home family interviewed reported they enjoy the activities programme and are not coerced to join in.

Activities for each resident are recorded on individual activity registers.

Lifestyle questionnaires are completed on admission and this is used to plan activities with residents in consultation with the resident when possible and their families.

Activities are planned that are appropriate to the capabilities of residents.

Residents are able to participate in an exercise programme as part of the facility's falls prevention initiative. There is also reminiscing, crafts, music and a variety of activities to maintain strength and interests.

D16.5d Resident files reviewed identified that the individual activity plan (which is part of the care plan) is reviewed at care plan review.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> D16.4a: Care plans are evaluated six monthly or more frequently when clinically indicated in the form of a new assessment and new a care plan which includes under each care plan goal the progress toward meeting the goal from the previous six months. Six monthly MDT meetings and subsequent care plan updates and review are very well documented and the service is commended on the MDT process and documentation, The care plan policy includes the evaluation requirements. Records of regular reviews with the GP have been maintained. D16.4a; Care plans are evaluated six monthly or more frequently when clinically indicated. The previous audit found that the effectiveness of analgesia was not always documented, As noted by 1.3.3.3 pain assessments are not always in place for the care plan , however two residents with prn analgesia reviewed specifically for evaluation of effectiveness had this well documented. This is an improvement on the previous audit.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> PA Moderate
<b>Evidence:</b> A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in line with accepted guidelines. The service has implemented the robotic sachets with regular reviews of the implementation of this new process to the service. The service is also in transition to new medication charts. With the rest home, still have some residual 'old charts' in use. D16.5.e.i.2; Medication are reviewed three monthly or as required by the G.P on all 12 medication files sampled. All medications used are prescribed for individual residents. The night registered nurse checks the medication on arrival from the pharmacy. Weekly checks of controlled drug register occur. Medication errors are reported and managed through the incident reporting process. The pharmacy is available for advice and support, as and when required. Unused or expired medicines are taken back to the pharmacy for appropriate disposal. Staff competencies are completed.

Staff responsible for medicine management have documented medication competencies. Registered nurses and care givers who administer medication received training in January 2014. Only registered nurses administer medications in the hospital.  
 No residents are currently self-medicating.  
 All documents and signing sheets are completed in ink and legible. Signature registers for staff and GPs are available to verify signatures in place.  
 Not all PRN medications have indications for use and signing sheets had incidents of non-signing for non-packaged medication. This is an area requiring improvement.

**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.

<b>Attainment and Risk:</b> PA Moderate
<p><b>Evidence:</b></p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in line with accepted guidelines.          The service has robotic sachets, which are delivered weekly.          D16.5.e.i.2; Medication are reviewed three monthly or as required by the G.P in all twelve medication files sampled. All medications used are prescribed for individual residents.          The night RN checks the medication on arrival from the pharmacy. Weekly checks of controlled drug register occur. Medication errors are reported and managed through the incident reporting process.</p>
<p><b>Finding:</b></p> <p>For the hospital and rest home, medication charts do not document indications for use with PRN medications. One of six medication charts do not have all medications signed for on administration in the rest home. In the hospital, three of six medication administration charts did not have all non-packaged regular medications signed for.</p>
<p><b>Corrective Action:</b></p> <p>Ensure that all medications are signed for on administration and ensure that PRN medications have indications for use documented.</p>
<p><b>Timeframe (days):</b> 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a large kitchen that prepares food for both the rest home and hospital. There is a small kitchen area in the hospital where food is served  
There are two cooks employed at Aroha. Both have current food handling certificates. There is a Local Council Food Hygiene certificate displayed with an "A" rating issued 24 July 2014. There is a five weekly rotating seasonal menu in place, which has been reviewed by a dietitian. Food and fridge/ freezer temperatures are monitored and records were sighted. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines.  
Meal times observed in both rest home and hospital are calm and managed well.  
Four rest home and four hospital resident praised the food services

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a current BWOFF that expires on 13 December 2014. The home is warm and well ventilated. All electrical equipment is checked and tagged bi annually this is current.

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

All buildings, plant, and equipment comply with legislation.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

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

**Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)**

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The previous audit found that chemicals were not always stored safely. This audit evidenced all chemicals were locked and secure.

**Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)**

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

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## Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

## Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

There is a restraint policy. There is a restraint manual applicable to the type and size of the service. The restraint manual includes a section on training that covers policies, procedures, challenging behaviours management, de-escalation techniques, emergency / acute restraint and appropriate use of safety enablers. Restraint training occurs yearly. Challenging behaviour training has been provided. Staff were familiar with the policy and the definition of enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and use of enablers.

The restraint manual determines that enablers are voluntary and the least restrictive option. There are no enablers in use in the facility and eight residents with restraints. There are documented three monthly restraint meetings with all residents with restraint reviewed at each meeting. There are regular restraint audits (Most recent October 2013).

### 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.)*

## Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

### Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

The previous audit found that monitoring forms for restraint were not always completed correctly. Three monitoring forms for restraint were reviewed specifically for this audit and all were completed appropriately. This is an improvement on the previous audit.

#### Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

**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

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### 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:**

Infection monitoring is the responsibility of the IC coordinator. The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities are appropriate to the acuity, risk and needs of the residents. The infection control coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly quality meeting and benchmarked through the QPS system. The infection control coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. Internal audit of infection control is included in the annual programme and there is evidence that changes occur to improve service as a result of audits and surveillance. An example includes increased eye infections resulted in documented plan to reduce infections with improved hygiene practices. Handovers discussed hygiene with staff and there has been a reduction in eye infections. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting.

#### 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.

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