# The Coast to Coast Hauora Trust - Heritage Rest Home

## Current Status: 12 March 2014

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

## General overview

The Coast to Coast Hauora Trust – Heritage Rest Home is located in Wellsford. The facility provides rest home level care for the community. This unannounced surveillance audit includes follow up on three required improvements from the previous audit. These have been completed. There is one area requiring improvement resulting from this audit. This relates to the use of the correct documentation form when residents are using enablers.

## Audit Summary as at 12 March 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

### Consumer Rights as at 12 March 2014

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

### Organisational Management as at 12 March 2014

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| 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. |

### Continuum of Service Delivery as at 12 March 2014

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| 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. |  | Standards applicable to this service fully attained. |

### Safe and Appropriate Environment as at 12 March 2014

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

### Restraint Minimisation and Safe Practice as at 12 March 2014

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of low risk |

### Infection Prevention and Control as at 12 March 2014

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

# HealthCERT Aged Residential Care Audit Report (version 3.91)

## **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**

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| --- | --- |
| **Legal entity name:** | The Coast To Coast Hauora Trust - Heritage Rest Home |
| **Certificate name:** | Heritage Rest Home Wellsford |

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| **Designated Auditing Agency:** | DAA Group |

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| **Types of audit:** | Surveillance | | | |
| **Premises audited:** | Heritage Rest Home | | | |
| **Services audited:** | Rest Home | | | |
| **Dates of audit:** | **Start date:** | 12 March 2014 | **End date:** | 12 March 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 15 |

## **Audit Team**

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

## **Sample Totals**

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

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| Number of residents interviewed | 3 | Number of staff interviewed | 6 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 3 | Number of staff records reviewed | 4 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 6 | Total number of staff (headcount) | 21 | Number of relatives interviewed | 0 |
| 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 the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Tuesday, 15 April 2014

## **Executive Summary of Audit**

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| **General Overview** |
| The Coast to Coast Hauora Trust – Heritage Rest Home is located in Wellsford. The facility provides rest home level care for the community. This unannounced surveillance audit includes follow up on three required improvements from the previous audit. These have been completed and there is one area requiring improvement resulting from this audit. This relates to the use of the correct documentation form when residents are using enablers. |

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| **Outcome 1.1: Consumer Rights** |
| Residents report on interview they are informed regarding any issues relating to changes to their care and are given choices. The correct complaints process is followed and residents and staff report on knowledge of the complaints process. |

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| **Outcome 1.2: Organisational Management** |
| Systems are established and maintained which define the scope, direction and objectives of the service and the monitoring and reporting processes. The philosophy, vision, scope and goals are appropriate for this level of service. The manager, who is also a qualified registered nurse, has appropriate experience and qualifications to perform this role and is responsible for the overall service delivery, business administration, quality systems and human resources management. The manager is supported by a clinical nurse manager and oversees all aspects of service delivery.   The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery. A comprehensive internal auditing programme for 2014 is in place. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisational management reflecting current accepted good practice.  The human resources management system provides for the appropriate employment of staff and on-going training processes. There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery in the rest home. Rosters and staff interviewed demonstrate that an appropriate number of skilled and experienced staff is allocated each shift and this meets the requirements of the provider's contract with the district health board. The education programme is available for 2014 and education records are well maintained. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| This rest home has processes implemented to assess, plan and evaluate the care needs of the residents. The experienced registered nurse reports to the manager who oversees the service delivery. The experienced staff perform their roles and deliver appropriate care and management to all residents. The registered nurse, in consultation with the multidisciplinary team, evaluates the care plans to ensure all needs are able to be effectively met. Any interventions are documented clearly to guide care staff. An area for improvement from the last audit in regards to documentation of evaluation of care plans has been managed effectively and verified in the residents’ records reviewed.  The activities programme is provided and enjoyed by the residents. The programme reviewed supports the interests, needs and the strengths of residents. Participation is encouraged but is voluntary. Outings in the community are arranged and entertainers from the community are welcome to participate in the programme.  Medication management is safely implemented and is appropriate for this rest home. A visual inspection of the medication system provides evidence of safety and compliance with respective legislation and guidelines. Policies and procedures clearly detail service providers` responsibilities. The registered nurse is responsible for medication management. Medication records were reviewed. The registered nurse and senior caregivers have received education and meet competency requirements. One area of required improvement from the previous audit in relation to medication management has been actioned and the general practitioners prescribe and sign off all medications individually.  The food service is well managed by the experienced cooks interviewed and appropriate for the service setting. The residents have choices and individual food, fluids and nutritional needs are met. Modified diets are made available with assessed special requirements. The menus have been recently reviewed by a registered dietitian and are suitable for the elderly. Meals are provided at appropriate times of the day. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The Heritage Rest Home has a current building warrant of fitness. The evacuation plan is approved by the fire service. There have been no building changes since the last audit. There is on-going upgrading of the bathroom areas and general maintenance.  Evidence is seen of updated education to all staff on emergency evacuations and fire and safety procedures. The previous corrective action has been completed. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has a restraint free environment and does not have any recorded restraint but has enablers in use. The care is flexible and individualised to promote quality of life that minimises the need for restraint through effective management of challenging behaviours. The service has clearly described restraint minimisation and safe practice policies and procedures which comply with the standard.  There is one area requiring improvement relating to the use of the correct consent form during the use of enablers. |

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| **Outcome 3: Infection Prevention and Control** |
| The service has infection prevention and control policies and procedures relevant to the rest homecare provided. The registered nurse is the infection control co-ordinator and oversees the surveillance programme. The outcomes of the surveillance programme are integrated as part of the quality system and staff receive feedback at their monthly meetings. There is evidence of staff receiving infection prevention and control in-service education as part of the orientation programme and this is ongoing. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 16 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 45 | 0 | 1 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 55 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(RMSP)S.2008 | Standard 2.1.1: Restraint minimisation | Services demonstrate that the use of restraint is actively minimised. | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 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. | PA Low | Two of the four residents’ charts reviewed show evidence of use of the incorrect consent form being completed. | CNM to implement the use of correct form with resident within 180 days | 180 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The three residents interviewed confirm communication with staff is open and effective. There is evidence in the three files reviewed that family are contacted following incidents (eg, falls) and involved in annual multidisciplinary meetings.  Policies identify that all aspects of care and service provision are discussed with the resident and their family/whanau prior to or at the admission meeting. Staff make adequate time to talk with residents and families (confirmed in interviews with five of the five clinical staff and the Clinical Nurse Manager (CNM)). There is sufficient space in each single room to permit private discussions or a lounge area as required.  Processes are identified in the Interpreter Policy. If necessary, an interpreter within the community is sought (confirmed in interview with the CNM).  ARRC requirements are met. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Concerns/Complaints Policy provides detailed information about the management of complaints including timeframes and the complainant’s right to seek and independent advocate. The policy states that a copy of the concerns/complaints form is given to residents on admission and is freely available upon request. There is evidence of investigation, actions and resolution of complaints or concerns. The process of any corrective action plans if required is documented in the register and reported at staff meetings. The records of complaints received provides evidence that complaints are documented, investigated and resolved. Three of the three residents interviewed stated they have been informed about the complaints process and are comfortable to talk to any staff.   ARRC requirements are met. |

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

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

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

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

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

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a manager/registered nurse with experience in the aged care industry and is supported by a clinical nurse manager (CNM) who oversees all aspects of service delivery, The manager reports to the community trust board monthly. She is responsible for all operational matters relating to the facility and overseeing the governance structures. The manager and the clinical nurse manager attend relevant education courses to ensure their practicing certificate is current attend all relevant education available with the WDHB and attend conferences/seminars relating to the aged care industry. The manager is responsible for ensuring the overall financial welfare of the service. The sighted job description for the clinical nurse manager describes the authority, accountability, and responsibility for the overall management.   There is suitably qualified staff on each duty and they are supported by on call management 24/7.  The relevant ARRC requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The quality improvement and risk management guidelines identify objectives, action, planning and support to reach identified goals. The overall objective is to meet the needs of all the residents and enhance satisfaction with support/care services and all services they provide. The quality plan covers all aspects of service delivery with actions shown on how to minimise identified risks, who is responsible and the timeframe for implementation. The business risk management plan covers being a good provider, responsible planning, safe environment, and internal audits. The organisation has a quality and risk management system which is understood and implemented by staff; as confirmed at interview with the seven of the seven(five caregivers, one cook ,one administrator) staff.  The service develops and implements policies and procedures that are aligned with current good practice and service deliveries, meets the requirements of legislation, and are reviewed at regular intervals as defined by policy. Policies are reviewed at least two yearly, or sooner if there are legislative changes. Policies sighted are reflective of good practice and all policies are reviewed by the manager and the clinical nurse manager.  Key components of service delivery are explicitly linked to the quality management system. The quality and risk management system is closely linked with the health and safety, complaints management and infection control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of the service delivery. Internal audits planned for 2014 include health & safety, fire drill, medication, cleaning and satisfaction surveys (sighted). Data is collected for all key performance requirements and analysed and evaluated monthly at the staff and management meetings (minutes sighted). The 13 of 13 staff interviewed report the quality improvement data, results from internal audits and areas of required improvement are reported back to them through the staff meeting and staff communication book/notice board.   Corrective action plans are developed from identified areas of improvement through the internal audits, hazards, incident forms, satisfaction surveys and the complaints management process. Corrective action request forms are documented and actioned as required to evidence the summary of the event, what has been learned, what actions were taken and why, and the outcome. The corrective actions analysis includes collation, review and actions implemented. A re-audit of the issue is conducted to review if the actions implemented are effective in minimising or eliminating the area of concern.   Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whanau of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted includes the identified risks, how these are monitored, and the severity of the risk and if the implemented actions can isolate, eliminate or minimise the risk. The risk register is maintained by the CNM.   The relevant ARRC requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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.

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

#### Standard 1.2.4: Adverse Event Reporting **(**HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The seven of the seven staff interviewed demonstrate understanding of the requirements for adverse event reporting. The manager and CNM have an understanding of their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The manager reports that there have been no incidents that have required essential notification.   The service documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. They are reviewed and analysed on a monthly basis. The adverse event forms are used for making improvements where required. The adverse event reports include a summary of the incident, immediate actions, corrective actions and outcomes. The follow up includes a re-audit of the implemented actions to review if the hazard has been controlled or eliminated.   Evidence is sighted of incident reporting, family notification and minutes of monthly quality/staff meeting.  The relevant ARRC requirements are met. |

##### **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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Professional qualifications are validated, including evidence of registration and scope of practice for the professional staff. Annual practising certificates are sighted for the RNs, GPs, pharmacist and podiatrist.  There are processes implemented for the appointment of appropriate staff to safely meet the needs of residents. The four of the four staff files reviewed (one CNM, two caregivers, one cook) demonstrate appropriate recruitment and employment processes. The recruitment and employment process includes advertising, interview process, reference checking, police vetting and qualification validation. The CNM reports that potential staff are assessed to ensure they have the positive attributes to enable them to work with the residents. There is a performance appraisal system, which is conducted at least annually for all staff (confirmed in the four of the four staff files reviewed). The new staff also have a performance review after the first three months of employment.   New service providers receive an orientation/induction programme that covers the essential components of the service provided. The orientation consists of a checklist, orientation shifts (with includes all shifts), and a handbook with the services key policies and procedures. The orientation covers the services philosophy and vision, the Code of Rights, complaints management, staff requirements (e.g. code of conduct), health and safety, basic care skills, infection prevention and control and food services. The orientation for all staff includes sessions on implementation of activities and the management of challenging behaviours. The four of the four staff files reviewed showed evidence of orientation and the seven of seven staff interviewed (five caregivers, one administer and one cook) confirmed they received an orientation that was effective in preparing them to work in the service.   A system is in place to identify, plan, facilitate, and record ongoing education for staff to provide safe and effective services to the residents. The ongoing in-service education plan for 2014 is sighted. The education provided in 2013 is appropriate for rest home level care. The service provides support for the staff to complete aged care education using an approved on line education programme (sighted). Attendance records are maintained in the education folder and in each individual staff member’s education record. Education planned for 2014 includes; management of challenging behaviours (November 2014), infection control (May 2014), consumer rights (April 2014), elder abuse and neglect prevention (December 2014). The education programme has specific topics in relation to care of the older person, such as skin care, documentation, manual handling, continence management, pressure are care, wound care, nutrition and communication. The education programme contains the essential and emergency requirements, such as fire safety and civil defence response. All staff have a current first aid qualification as confirmed at interview with the CNM and seven of seven staff interviewed. This is sighted in the four of the four staff files reviewed. ARRC requirements 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a clearly documented and implemented process which determines staffing levels and skill mixes in order to provide safe service delivery and the layout of the service. The rest home service is provided from the one building.  Either the manager or the CNM are on site Monday to Friday and one is on call when offsite. The CNM provides support and direction to the all staff and shares on call with the manager.  The activities coordinator role is part of a shared caregiver role and ensures that activities are available 24 hours a day and seven days a week (24/7) for all residents. Caregivers are undertaking a “Clinical Update” Online Programme that has two topics that meet the NZQA Standards (Infection Control 20826 and 27142 and Abuse and Neglect 1836). They are working towards all other topics that meet required unit standards.  On review of the roster there is evidence of sufficient staff to ensure safe staffing levels on all shifts over 24 /7 days. The three of three residents report satisfaction with the skills of the staff and the care provided.   The relevant ARRC requirements are met. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies and procedures in place to identify how residents receive timely, competent and appropriate services to meet their needs as identified by the assessment process. The registered nurse interviewed is responsible for each resident assessment, initial care plan development and discussed the development of the long term care plan. The initial care plan is developed by the registered nurse within twenty four hours of admission by taking into consideration the needs assessment services co-ordination assessment completed prior to the resident being admitted to this service. The long term care plan is developed within three weeks of admission. The long term care plans reviewed evidence set goals for the resident, with clear interventions to meet these goals and also identifies and reflects the physical, psychosocial and cultural aspects pertinent for each resident. The residents’ records sighted have all been reviewed six monthly or more often if required. The resident`s family/whanau are involved and this is evidenced in the records reviewed.   Handovers are provided between shifts and this was observed between the morning and the afternoon staff. The afternoon staff caregivers come on shift at 1230 and work with the morning staff over the lunchtime period to assist residents at the mealtime and to their individual rooms or into the lounge. Additional work in the laundry is completed after lunch by one staff member and assistance with the activities programme is encouraged. Continuity of care and team work is promoted. There are two general practitioners who cover this service and one was available to be interviewed. The GP stated that the two GPs visit regularly and are available for the service after hours if and when required. The GP also stated that there is good communication between the GPs and the registered nurse responsible for this service. The registered nurse reports to the manager of the service who is also a registered nurse.  There is an effective staff training monthly calendar available for caregivers to complete on-line and this programme is displayed in the nurse`s office. The registered nurse is linked into the Waitemata District Health Board (WDHB) residential aged care integration programme and attends education sessions available as able. The nurse practitioner assigned to this rest home from WDHB Health Services for Older People services visit is this rest home and is available to run in-service education by arrangement with the registered nurse and/or manager.  The registered nurse has recently completed the full training for interRAI (a comprehensive clinical assessment for people living in aged residential care) which will be compulsory for the aged care sector. Registered nurses have to be trained by 2015. The registered nurse spoke of this assessment process will be implemented 2014 – 2015 for this service.  Tracer methodology: Rest home XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  The ARRC requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Short term care plans are used for problems that can be resolved in a relatively short time. There is evidence that these are in place in the three of three residents’ records reviewed. The long term care plans reviewed record interventions that are consistent with the residents` needs and goals that are set. The family is notified if there is any changes to the care plan and this is recorded on the resident/family/whanau communication record sheet in the individual resident`s record. Observations on the day of the audit indicate residents receiving care that is appropriate and consistent with the individual resident`s needs. The caregivers interviewed report that the care plans are up to date and do reflect the individual resident`s needs and are able to be followed easily.  The ARRC requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The activities programme sighted is managed and implemented by the registered nurse and is overseen by an occupational therapist every two years. The individual assessment is completed by the registered nurse during the initial assessment process. The strengths, skills and interest of each resident is recorded. The individual activities plans sighted are developed from this information gained and presently all plans reviewed are current and up to date.  The registered nurse interviewed in relation to the activities programme is improving the activities programme with increased one on one activities and taking residents out for walks. A resident advocate visits the residents daily and spends time with several residents on a one on one basis each day. Two caregivers come on duty at lunchtime and help with assisting residents with lunch and activities.  Designated times such as 1015 to 1045 and 1300 to 1400 are used solely for group activities. Church services, music sessions, library, movies, word quiz games, DVDs, herald readings and lots more are provided to the residents. Residents interviewed enjoy the activities and one resident interviewed enjoys the company of others and participating on a voluntary basis. The rest home has a cat and parrot observed in the main lounge. There is a separate lounge that can be used for activities as well as the main lounge. The activities plans are evaluated at the same time the nursing care plans are reviewed every six months or sooner if and when required.  The ARRC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy identifies that care plans are evaluated six monthly or if there is a change in the resident`s condition they are updated accordingly. Interventions are changed if required to ensure all needs and goals set can be effectively met. This was an area of improvement identified in the last audit 1.3.8.2 which is now fully attained. The registered nurse interviewed stated that it is a responsibility to ensure all care plans are evaluated timely and as per protocol. The three of three records sighted have been reviewed appropriately, signed and dated by the registered nurse. If progress is different from expected the relative information is communicated to the resident, family/whanau.  The ARRC requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a medication policy that is reflective of current safe practice guidelines and legislative requirements are acknowledged. The policy identifies that staff who administer medicines must be competent to do so. There are ten experienced caregivers and one registered nurse who have all completed medication competencies and these records are maintained by the manager who oversees the service delivery and/or the registered nurse. Six of six medication records reviewed are current and up to date with evidence of three monthly reviews by the two general practitioners who are contracted to this service. The records have photo identification on the front record sheet and on the signing medication record sighted. Staff signatures can be verified.  The medication system implemented is clearly understood by the caregivers interviewed and the lunchtime medication round was observed and performed safely. Any allergies are clearly documented and highlighted on the medication records reviewed. The GP and the registered nurse interviewed report safe practice is identified and good communication exists between the pharmacist, the GP and the registered nurse and senior caregivers for this small aged care service.  No residents self-medicate medicines. Pharmacy reconciliation occurs monthly when preparing the blister pack medications at the pharmacy. The medication trolley is locked at all times when not in use and remains in the nurses’ office. There was an area of improvement identified at the last audit 1.3.12.6 in relation to medication transcribing but this no longer occurs. Each medication is prescribed and signed off at the time by the GP and this is verified on the six of six resident medication records reviewed.  The ARRC requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are details related to nutritional and safe food and fluid management policies in place. The policies cover all aspects of this standard including additional or modified nutritional needs, and weight loss management. All residents are assessed on admission and any likes and dislikes, food sensitivities or allergies are communicated to the cook and recorded on the initial and long term care plans. There are two cooks who share this role. The main cook works Monday to Friday 0700 to 1400 and the other cook covers the weekends. The weekend cook provides cover for the main cook as required and is also an experienced caregiver.  The menus are documented in four weekly cycles and summer and winter meals plans are available. The contracted dietitian has recently reviewed the summer menu and an email letter dated 20 February 2014 is available to verify this has occurred. Some changes were made to enhance the menu and to suit the majority of the residents. The annual practising certificate of the dietitian has been recorded and is valid.   The kitchen and dining open plan provides a homely environment for residents. Assistance is provided to the residents as required at meal times by the caregivers. The cook interviewed has been at this facility for 13 years and the weekend cook for four years. Both interviewed are passionate about their roles. The cook is responsible for ordering food from contracted services or from local providers in the community especially for fresh fruit and vegetables, meat, bread and milk.  The cook is responsible for monitoring the weekly fridge temperatures on a Monday. The main pantry sighted is outside of the facility near the management office and is always accessible. All foods are stored appropriately and stock is rotated on a regular basis. The dietitian can order supplements for a resident if required. Special diets can be arranged for example puree, fortified fluids, vegetarian diets or gluten free or any other types of food requirements can be met. The cooks have completed relevant food safety courses and their own personal records are maintained by the registered nurse interviewed.  The ARRC requirements are met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The building warrant of fitness expires in 30 June 2014.   All buildings, plant, and equipment comply with legislation. The electrical test and tag is due in November 2014. The medical equipment calibration was last conducted August 2013. The equipment calibration includes the blood pressure monitors, thermometers and hoists.   The hot water temperatures are checked in resident areas monthly. The temperatures are all within required limits.   There is a planned and ongoing maintenance plan (sighted). This includes upgrading of bathrooms and painting of all areas of the facility as required.  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents at rest home level of care.   Residents are provided with safe and accessible external areas that meet their needs. There is adequate outside sitting area with shelter as required. All rooms are suitable for either rest home level care.   The relevant ARRC requirements are met. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staff receive appropriate information, training, and equipment to respond to identified emergency and security situations. The fire drill was conducted in January 2014 at the same time as earthquake and fire emergency training (evidence sighted).   The rest home has a civil defence kit, with adequate food and water for a minimum of three days. There are adequate torches and blankets in the case of an emergency. Trial evacuations of residents are conducted at least six monthly and these are carried out at different times of the day (records of last fire drill October 2013). The system is used for monitoring a safe/secure environment and reviewing any adverse events (as confirmed at interview with the manager). Evidence is seen of first aid and emergency training given to staff. The previous corrective action has been completed.  The rest home has a call bell system in all resident areas. There is an audible alert and a light above the room where the call bell is activated. The three of the three residents report a timely response to the call bells.   The ARRC requirements are met. |

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

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

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

##### **Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation plan.

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

##### **Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

Alternative energy and utility sources are available in the event of the main supplies failing.

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

##### **Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

An appropriate 'call system' is available to summon assistance when required.

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

##### **Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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

# NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is no recorded restraint use at the service but there are four enablers in use as confirmed at interview with the CNM and caregivers. As sighted in the services policy if enablers are to be used, they shall be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining consumer independence and safety.   Staff training in restraint minimisation (February 2014) and strategies for managing challenging behaviour, understanding delirium, confusion and dementia are frequent in-service education topics. Training records show education provided by the CNM and external presenters. The four of the four caregivers interviewed demonstrate knowledge on restraint and enabler use and the minimisation of challenging behaviours.    There is a corrective action required relating to the use of the correct consent form for enabler use (evidence is seen in 2 of the 4 files reviewed) Management are in the process of introducing the correct form.  All other aspects of the approval and consent process are met for enablers. ARRC requirements are met.  The ARRC requirements are met. |

##### **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.

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| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Two of the four residents’ charts reviewed show evidence of use of the incorrect consent form being completed. |
| **Finding:** |
| Two of the four residents’ charts reviewed show evidence of use of the incorrect consent form being completed. |
| **Corrective Action:** |
| CNM to implement the use of correct form with resident within 180 days |
| **Timeframe (days):** 180 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy identifies that surveillance data is used to identify trends and corrective planning is put in place as appropriate. Clear definitions of surveillance and types of infections are documented to guide staff. The surveillance programmed is suitable for the size and nature of this service. The registered nurse is responsible for surveillance for this rest home. Each resident has a monthly infection analysis record sheet in their individual record which documents the name, date, sort of infection, specimen or swab sent to laboratory, any sensitivities received, antibiotics if prescribed and length of time and any follow-up provided.  Expert advice can be sought from the two contracted GPs or the nurse practitioner who visits the facility regularly from WDHB health services for older people and/or the infection control nurse specialist and/or team from WDHB. There have been no infection outbreaks reported since the last audit. The pharmacist is also available for advice if required or advice can be obtained through the laboratory microbiologist. Education is provided to residents as required and to staff on a regular basis.  The ARRC requirements are met. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **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.

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| **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.)* |