# Kingswood Healthcare Matamata Limited

## Current Status: 4 April 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

An unannounced surveillance audit is conducted at Kingwood Healthcare Matamata. The service provides specialist secure dementia care for up to 25 residents. At the time of audit there are 19 residents at the service. The service implements the Spark of Life philosophy for person centred care to residents living with dementia.

The previous audit identified eight areas requiring improvement; these are now all implemented.

There are no areas requiring improvement identified at this audit.

## Audit Summary as at 4 April 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 4 April 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 4 April 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 4 April 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 4 April 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 4 April 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. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 4 April 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 4.0)

## **Introduction**

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | Kingswood Healthcare Matamata Limited |
| **Certificate name:** | Kingswood Healthcare Matamata Limited |

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

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| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Kingswood Rest home | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 4 April 2014 | **End date:** | 4 April 2014 |

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| **Proposed changes to current services (if any):** |
| The service now provides secure specialist dementia care only. There has been no increase in bed numbers since the previous audit. |

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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 19 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 4 | **Hours off site** | 4 |
| **Other Auditors** | XXXXX | **Total hours on site** | 4 | **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 | 8 | Total audit hours off site | 10 | Total audit hours | 18 |

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| Number of residents interviewed | 1 | Number of staff interviewed | 6 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 3 | Number of staff records reviewed | 3 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 6 | Total number of staff (headcount) | 15 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed |  |

## **Declaration**

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

I confirm that:

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

Dated Tuesday, 15 April 2014

## **Executive Summary of Audit**

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| **General Overview** |
| An unannounced surveillance audit is conducted at Kingwood Healthcare Matamata. The service provides specialist secure dementia care for up to 25 residents. At the time of audit there are 19 residents at the service. The service implements the Spark of Life philosophy for person centred care to residents living with dementia.  The previous audit identified eight areas requiring improvement; these are now all implemented. There are no areas requiring improvement identified at this audit. |

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| **Outcome 1.1: Consumer Rights** |
| The family/whanau interviewed report that there is a good standard of communication at the service and that information is conveyed in an open and honest manner. Access to interpreter services is documented in the interpreter service policy, which contains contact numbers for interpreter services.  The right of the residents and family/whanau to make a complaint is understood, respected, and upheld at the service. The service has an easily accessed, responsive and fair complaints process. There is an up to date complaints register and folder that includes the complaints, dates and actions taken. |

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| **Outcome 1.2: Organisational Management** |
| The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of residents living with dementia. The purpose, values, scope, direction, and goals of the organisation are clearly identified and reviewed annually. The philosophy of the service incorporates the Spark of Life approach for person centred dementia care. The general manager 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 general manager is supported by a full time registered nurse (RN) and has support and advice through an external nurse practitioner for the clinical aspects of service delivery. The last audit identified that the service provided rest home and secure level of care and that the resident areas are not separated from the rest home and dementia level of care residents, as required to meet contractual requirements. This is no longer applicable as the service only provides specialist secure dementia care. The service has established and documented quality and risk management systems. Quality outcomes data is analysed to improve service delivery through the internal auditing process and reviews of adverse events. The adverse event reporting system is a planned and co-ordinated process, with staff documenting adverse, unplanned or untoward events. The previous audit identified shortfalls in the implementation of the corrective action process. This is now addressed and an area of improvement implemented since the last audit.  Policies and procedures are developed 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 in-service education processes. There is a clearly documented rationale for determining service provider levels and skill mix in order to provide safe service delivery that meets the needs of the residents. Rosters and staff interviewed demonstrate that an appropriate number of skilled and experienced staff are allocated each shift and this meets the requirements of the provider's contract with the district health board. All staff are provided with ongoing education on the Spark of Life and the required national unit standards in dementia care.   Information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring dementia care. Staff are trained and qualified to perform their roles and deliver all aspects of service provision. All residents are assessed on admission and assessment details are retained in the individual resident`s records. The residents’ care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required, with resident and family input being sought. Short term care plans are used as required to guide service delivery for residents who have short term needs. A nurse practitioner and a general practitioner from the local surgery report that all residents are seen on admission and explained that full medical cover is provided for all residents 24 hours a day. Documentation is reviewed within timeframes as required for this service. The previous required improvement has been completed.  The activities available are appropriate for residents requiring dementia care. The programme revolves around the Spark of Life philosophy and all staff attended training in February 2014.   Medication management systems comply with current legislation and all clinical staff involved in medicine management undergo competency assessment annually. The general manager and RN are responsible for all areas of medication management and work alongside a contracted pharmacy. Previous required improvements have been addressed.  The food service is prepared on site but contracted to an external company. The menu plans have been reviewed and approved by a contracted dietitian to ensure they are suitable for the elderly in residential care. Each resident is assessed by the RN on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. A copy of the nutritional profile is retained in the records and the kitchen is notified of any special food requests. Visual inspection of the kitchen provides evidence of compliance with current legislation and guidelines. All kitchen staff have completed food safety training. Meals are provided at appropriate times of the day. Family/whanau interviewed report satisfaction with the food service provided. The previous required improvement has been completed. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The service has a current building warrant of fitness. There are no changes made to the layout of the service since the last audit. The previous audit identified an area requiring improvement related to the maintenance of handrails in two of the toilets. The handrails have been replaced. The approved evacuation plan was not sighted at the previous audit; this is now addressed. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has a commitment to restraint minimisation and safe practice. There is a clearly described restraint minimisation and safe practice policy which complies with the Standard available to guide staff. There are no restraints or enablers in use. Staff receives training in safe and effective alternatives to restraint, such as de-escalation techniques for managing challenging behaviour. Staff interviewed understand that the use of enablers is a voluntary process along with approval and informed consent processes. Safety is promoted at all times. |

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| **Outcome 3: Infection Prevention and Control** |
| 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. There is monthly surveillance of infections, with the data analysed and reported to staff and management through staff meetings. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 21 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 44 | 0 | 0 | 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 | 29 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 57 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
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## **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:** |
| Family/whānau communication is clearly documented in the three of three resident file reviews conducted and on incident and accident forms sighted. The two of two family/whanau interviewed report they receive full and frank information from staff. The one resident informally interviewed, although reporting satisfaction with the service, is not able to provide insight into the communication process.   Wherever necessary and reasonably practicable, interpreter services are provided. Contact details for the interpreter service are clearly set out in resident admission information and in policy. There are no residents who require interpreter services at the time of audit.   The Aged Related Residential Care (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 service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code of Health and Disability Services Consumers’ Rights (the Code). The internal audit for the concerns and complaint process (conducted February 2014) records that the times fames at Right 10 of the Code are met. The time frames are confirmed in the two complaints sighted. The resident/family information book contains information on how to make a complaint, a complaint form is provided in the admission pack and the complaints forms are available at the entrance to the service. Client advocacy and contact numbers are available. The complaints register folder records two complaints since the previous audit. All complaints, dates and actions taken are recorded in the folder.   The two of two family/whanau interviewed report that management are easily approachable if they have any concerns. One resident is informally interviewed but not able to provide insight into the complaints process. |

##### **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 documented mission statement is ‘providing dignified care for the elderly’. The purpose, values, scope, direction, and goals of the organisation are clearly identified and reviewed at least yearly. The internal audit of the organisational management systems was last conducted in January 2014. The Spark of Life approach to care is integrated into the vision, scope and goals of the service. Through the Spark of Life philosophy the service aims to re-ignite the human spirit, boost self-esteem and bring joy of life to residents living with dementia.   The Kingswood homes are owned by Kingswood Healthcare Holdings, which is a family owned business. The general manager oversees the day to day operations and is supported by a team of registered nurses (RNs) and care staff. The general manager reports to the directors of Kingswood Healthcare at least monthly. The general manager reports that this is often daily.   The service has a general manager with over 20 years’ experience as an administrator and manager in the private hospital setting in South Africa. The manager has over six years’ experience as a business manager and in caregiving roles in a specialist dementia unit in New Zealand. The general manager is a shareholder of other aged care service in Morrinsville and Cambridge. The general manager has over 8 hours education in the management of care services in the past 12 months. This includes ongoing education and support through the Aged Care Association management network, human resources management, and specific education related to aged care and dementia care in 2013 and staff management/disciplinary management in February 2014. The general manager has attended specific education on dementia care and the Spark of Life club programme in February 2014. The general manager is responsible for ensuring the overall financial welfare of the service. The sighted job description for the general manager describes the authority, accountability, and responsibility for the overall financial management.   The general manager is supported by a full time registered nurse (RN) for clinical service delivery. The facility also has clinical oversight and advice available from a nurse practitioner.   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 1.2.2: Service Management **(**HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous audit identified an area of improvement at criterion 1.2.2.2 that the living, bathing, toilet and outdoor areas of residents receiving rest home level of care are not separated from the specialist dementia service. The service now only provides specialist dementia level of care. The previous corrective action is no longer applicable as the service provides dementia level of care only. |

#### 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 previous audit identified a corrective action at criterion at 1.2.3.8, that although there is a corrective action process in place, this is not currently connected to the internal auditing process. It was identified that not all audits sighted at the previous audit had documented corrective actions or if the corrective actions had been closed out. This is now addressed and an area of improvement implemented since the last audit.   The organisation has a quality and risk management system which is understood and implemented by service providers. The six of six staff interviewed (two RNs, two caregivers, one cook and one activities coordinator) demonstrate knowledge of the quality and risk management systems.   There is a document control system to manage the policies and procedures. This system aims to ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents. The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meets the requirements of legislation, and is 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 general managers and senior RN. When new policies are introduced, these are circulated to the staff and staff sign a log to indicate that they have read the policy/procedure. There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures are accessible by staff. The footer of each document contains the version control information.  A process to measure achievement against the quality and risk management plan is implemented. This is monitored through the internal auditing process. 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 sampled for 2013 include cleaning and laundry, organisational management, complaints/concerns, food safety and care planning. Data is collected for all key performance requirements and analysed and evaluated monthly at the staff and management meetings (minutes sighted). The six of six 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.  Quality improvement data is collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, the resident. The service has an internal auditing schedule. The internal audits sampled for 2014 include the finding, actions taken and when completed. When corrective actions are required to be implemented, a corrective action form is used. The corrective action form records the problem identified, corrective action plan, date when corrective action is completed, if the problem is resolved and re-audit of the problem/issue. The corrective action forms record the feedback back that is provided to the manager, staff, resident, family or community (as required). The corrective action plan sighted for 2014 identify (five corrective action forms sighted) addressing areas requiring improvement are developed and implemented.  Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted includes the identified risks, how these are monitored, 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 facility manager. The risk register is maintained for each area of the service. A list is located in each area of the service, for example, the kitchen and medication room. Manual handling and biological hazards, chemical hazards and contractors on site are all recorded. |

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

##### **Criterion 1.2.3.6 (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 six of six staff interviewed demonstrate understanding of the requirements for adverse event reporting. The general manager has an understanding of their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The general 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. The general manager reports that from a review of accidents and incidents related to falls, the service has purchased more sensor mats to assist in falls prevention strategies for residents.   The 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 service providers. The annual practising certificates are sighted for all staff that require them.   The appointment of appropriate service providers to safely meet the needs of residents occurs. A review of three of three staff files and staff interviews confirm that the orientation process prepares staff for the roles they undertake. New staff receive an orientation/induction programme that covers the essential components of the service provided, which includes the services philosphy on the Spark of Life and the management of residents living with dementia. The six of six staff interviewed confirm they received an adequate orientation when they commenced work.   There is a system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to residents living with dementia. The service has a planned education programme (in-service programme and attendance sheets sighted for 2013 and to date in 2014). The education provided meets the requirements of the standards and contractual requirements with the DHB. The caregivers have completed or enrolled in the required dementia specialists unit standards. |

##### **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:** |
|  |
| **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:** |
| The staffing rationale policy identifies that the staff guidelines from the District Health Board are adopted for minimum staffing levels. The general manager demonstrates a commitment to ensuring that at all times there are adequate numbers of suitably qualified staff to provide timely, safe and appropriate services.  The roster sighted evidences an RN onsite Monday to Friday, an on call after hours. For the current resident numbers there are two caregivers on duty for morning, afternoon and night shift. The general manager and six of six staff report that the roster is flexible and the number of staff is increased when at full occupancy (eg, an additional afternoon shift caregiver).   There are adequate activities, administration, housekeeping, maintenance and catering staff to meet the needs of the service. The catering service is a contracted service. |

##### **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.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Information is entered into the resident information management system in an accurate and timely manner, appropriate to the service type and setting. On admission the admission details and unique identification NHI for each resident is obtained. The three of three residents’ files sighted have accurate and timely information entered into the residents care and administration file. Archived records are stored securely on site, these are retrievable as required. The records of past residents are securely destroyed in time frames that comply with legislation.   Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. The resident’s files are securely stored in a locked staff office.   All residents’ records are legible and the name and designation of the service provider is identifiable, as confirmed in the three of three residents files reviewed. The service uses a mix of paper based and electronic assessment and records. The electronic records are password protected and secure log in is required to access resident information. All records pertaining to individual residents are integrated, as sighted for the three of three residents files reviewed.  The relevant ARRC requirements are met. |

##### **Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)**

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and 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.)* |

##### **Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)**

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

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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 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

All records are legible and the name and designation of the service provider is identifiable.

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

All records pertaining to individual consumer service delivery are integrated.

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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:** |
| Service delivery documentation is overseen by the RNs. Documentation is part of the audit process and reviewed at regular intervals to ensure documentation is completed within required timeframes. In the three files reviewed there is evidence of initial assessments and care plans being completed and clinical risk tools being reviewed in the required time frames.  Kingswood Health Care uses the interRAI computer programme for assessments and an in-house computer programme for long term care plans. The long term care plan template is personalised, reviewed and amended within required timeframes. The clinical risk assessments and follow up times for documentation reviews are all completed.  The RNs report there is a process for six monthly multidisciplinary resident reviews. There is evidence in the three files reviewed that the family/whanau are involved in any care changes and reviews. Handover at the beginning of each shift is undertaken in the nurses’ station for privacy. Kingswood Health Care have the services of GPs at the local surgery and a Nurse Practitioner who visits weekly or at other times if required. The GPs share on call 24 hours a day, seven days a week (24/7) cover for all residents.  The five clinical staff interviewed (two RNs, two caregivers and one activity coordinator) report that the Mental Health Services for the Older Person (MHSOP) from the WDHB visit as required and a referral is made to a dietitian for unexplained weight loss.  The two relatives interviewed are very positive about the staff, GP and all aspects of care. The five clinical staff interviewed report that they are kept up to date with all clinical changes.  Tracer Methodology Dementia Care:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  ARRC requirements are met. |

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

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

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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 1.3.5: Planning **(**HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The planning of care is discussed with the family. In all three files reviewed evidence is sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these include 24 hour challenging behaviour monitoring, falls risk and pressure area risk. All health professionals document in the resident's individual clinical file. Documentation in all three files reviewed include nursing notes, medical reviews and hospital correspondence. In all three residents' files reviewed there is evidence to demonstrate involvement in care planning of the family/whanau. The two families report they are totally consulted in all aspects of their relatives’ care. The clinical staff report on interview they are updated at handover, or earlier, of any care changes. The previous corrective has been completed.  ARRC requirements are met. |

##### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

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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:** |
| In the three files reviewed there is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are assessed at required timeframes to ensure residents’ desired outcomes are being met. A specific example is a resident whose family reported on admission that he did not like to eat with other residents. There is evidence the clinical staff have implemented a plan to ensure that if he chooses he is able to eat in his room or a quiet area of the dining room.  The five clinical staff interviewed report they are informed of any care plan changes at hand over and have relevant in-service education as required.  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:** |
| There is one activities coordinator who works a total of 40 hours each a week employed a Kingswood Health Care. The activity coordinator has completed the ACE programme including the dementia standards. Activities are available for all residents over seven days as the caregivers undertake activities during the hours when the activity coordinator is not on site.  The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents. During interview the activity coordinator reports that it is important to have activities at similar times each day as the residents get into a routine. They reinforce that physical activities are best in the morning as this is the residents’ more alert times, and just before lunch the coordinator reports she has a sing along to stimulate the residents’ prior to lunch. As the facility is in a rural setting the local staff bring farm animals for the residents to enjoy, the residents assist with hanging out the washing and have their own raised garden.  External visits for the residents include the RSA for lunch, Sunshine Club and art groups. The Spark of Life philosophy is introduced in the dementia unit and evidence of this is seen. The two relatives report on interview the activities are positive and include walking and music.   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:** |
| In the three files reviewed evidence is seen of documentation if an event occurs that is different from expected and requires changes to service. Individual short term care plans are seen for wound care, infections and challenging behaviours. These are kept in an individual folder and each shift documentation is made in the file. These are transferred to progress notes when completed or transferred to the long term care plan.  Long-term care plans are reviewed every six months or earlier as required. Evidence of this was sighted in the three files reviewed. Progress notes are signed once a week by RN and each duty by the caregivers. Evidence is seen of the family/whanau involvement in the care reviews. The two relatives report that they are given the opportunity to be involved in all aspects of care and reviews.   The five clinical staff interviewed have knowledge of the care plan documentation requirements.  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:** |
| Kingswood Health Care uses the robotic medicine system whereby medicines are delivered monthly except for PRN medication which are delivered as required. When the robotic medicines are delivered they are checked by the RN and evidence is seen of the signing sheet. There are no controlled drugs on site on the day of audit. All processes comply with legislative requirements. There is evidence in all six files reviewed that medication charts are reviewed three monthly by the GP. The previous corrective action has been completed. There are no standing orders used at this facility. Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The RN reports that the GP works with the pharmacy but he/she is responsible for all medicines administered to his residents. If medicine is brought in by family this is approved by the GP and he/she charts on the medication sheet. The RNs or a competent caregiver are responsible for medication rounds. Evidence is seen of the designated staff having up to date competency for medicine management and administering medicines. The previous corrective action has been completed. There is no self-administration of medicines at Kingswood Health Care. Medicine sheets are signed in ink as required following administration.  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:** |
| Kingswood Heath Care operates a four weekly menu cycle approved by a dietitian (sighted). The previous corrective action has been completed. An individual dietary assessment is completed on admission which identifies individual needs and preferences. Likes and dislikes are identified as part of the admission assessments. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans.  The service is contracted externally to a registered food services company. Evidence is sighted of meal planning, cleaning routine and audit requirements being completed. There are two cooks who work over seven days. Both are up-to-date with their food safety certificates. Evidence is seen of attendance at annual updates on infection control and first aid. The cook reports that she is supported by management with food supplies and understands the individual requirements of the residents.  If residents require assistance with feeding a caregiver is available to assist. 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:** |
| There is a current building warrant of fitness that expires 8 July 2014. |

#### Standard 1.4.3: Toilet, Shower, And Bathing Facilities **(**HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| A previous corrective action at criterion 1.4.3.4 identified that hand rails around two of the toilets have a large amount of chipped paint. The sighted handrails are replaced with stainless steel handrails and have intact surfaces. This is an area of improvement implemented since the last audit. |

#### 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:** |
| The previous corrective action at criterion 1.4.7.3 identified that the fire evacuation plan was not sighted. The approved evacuation plan is sighted and dated as approved by the fire service in June 2013. This is an area of improvement implemented since the last audit. |

##### **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:** |
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| **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:** FA |
| **Evidence:** |
| The general manager reports they have a non-restraint environment and there are no enablers in use. The five clinical staff report on interview that there are no restraint or enablers used in the facility. They understand the difference between restraints and enablers and report that they have education on managing challenging behaviours (evidence sighted). Challenging behaviour is monitored on admission and kept as a short term care plan and transferred to long term care plan once the resident is settled in the dementia unit.  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:** 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.)* |

# 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:** |
| The type and frequency of surveillance is clearly stated in policy and is appropriate to the complexity of the organisation. Surveillance methods, analyses and responsibilities are clearly described within the infection control policy. Policy states that surveillance will be presented at staff meetings. An annual summary of the number and type of infections per month is maintained and sighted for 2013 and to date in 2014.  A register is kept of all residents who develop infections, the type of infections, results of cultures (where obtained) and details of treatment provided. The register notes whether further follow-up is required. The data is entered into the computer each month and reports of surveillance data is presented at monthly staff meetings.  Evidence is sighted of surveillance data from the initial completion of the infection notification form, with the analysis recorded at the staff meetings.  The 2014 surveillance data records an increase in urinary tract infections (UTIs) in January and February 2014 (two in January and three in February). A notice to staff regarding the importance of encouraging fluids and the importance of hand hygiene is sighted. The staff meeting minutes regarding infections identified a trend with one resident. The infection control coordinator reports that random hand washing audits have also been conducted with staff. The number if UTIs decreased to one in March 2014.  Staff report they are notified of any infections at handover and families are contacted as required. |

##### **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:** |
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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 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:** |
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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.)* |