# Edenvale Trust Board

## Current Status: 29 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

Edenvale Rest Home is owned by the Open Brethren Church Trust who operate under the name of Edenvale Trust Board. All services are overseen by a manager who is supported by a clinical leader who is a registered nurse.

The facility has a total of 41 beds, 29 bed can be used for either rest home or hospital and 12 beds are dedicated secure dementia care. On the day of audit there are 12 hospital, 17 rest home and 12 secure dementia care beds occupied.

Two improvements required from the previous audit have been fully addressed. There are two new areas identified as requiring improvement related to medication sheet signing and complaints management. The requirements of the provider's contract with the District Health Board are met.

## Audit Summary as at 29 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 29 April 2014

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

### Organisational Management as at 29 April 2014

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 29 April 2014

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

### Safe and Appropriate Environment as at 29 April 2014

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

### Restraint Minimisation and Safe Practice as at 29 April 2014

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 29 April 2014

|  |  |  |
| --- | --- | --- |
| 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**

|  |  |
| --- | --- |
| **Legal entity name:** | Edenvale Trust Board |
| **Certificate name:** | Edenvale Trust Board |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Edenvale Rest Home | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 29 April 2014 | **End date:** | 29 April 2014 |

|  |
| --- |
| **Proposed changes to current services (if any):** |
|  |

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

## **Audit Team**

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

## **Sample Totals**

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 7 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 30 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed |  |

## **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 DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of The DAA Group Limited | Yes |
| b) | The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | 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 Thursday, 15 May 2014

## **Executive Summary of Audit**

|  |
| --- |
| **General Overview** |
| Edenvale Rest Home is owned by the Open Brethren Church Trust who operates under the name of Edenvale Trust Board. All services are overseen by a manager who is supported by a clinical leader who is a registered nurse.  The facility has a total of 41 beds, 29 bed can be used for either rest home or hospital and 12 beds are dedicated secure dementia care. On the day of audit there are 12 hospital, 17 rest home and 12 secure dementia care beds occupied.   One improvement required from the previous audit has been fully addressed. There are two new areas identified as requiring improvement related to medication sheet signing and complaints management. The requirements of the provider's contract with the district health board are met. |

|  |
| --- |
| **Outcome 1.1: Consumer Rights** |
| The families/whanau interviewed report that there is a good standard of communication at the service and that information is provided 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 organisation respects and supports the right of the resident to make a complaint. The manager confirms there have been no external complaints, issues based audits, coroner’s inquests or police investigations since the last audit. One area requiring improvement relates to not all complaints being identified in the complaints register. |

|  |
| --- |
| **Outcome 1.2: Organisational Management** |
| At governance level there are processes in place to ensure services are planned, co-ordinated and appropriate to the needs of residents. This process is overseen by the manager who reports to the Board of Trustees. She is supported by a clinical leader who is a registered nurse (RN).    Edenvale Rest Home has well established quality and risk management systems which are fully implemented. Quality is reviewed and measured through an internal audit schedule and deficits are corrected through use of corrective action planning, which is monitored by the quality and risk monitoring group.   Resident and family/whanau interviews confirm they are kept informed of any adverse events and this is supported by documentation sighted. This was an area identified for improvement in the previous audit and is now fully attained.   Human resources management processes in place meet legislative requirements. Staff are fully supported by the organisation to maintain and improve their knowledge and skills through on-going education both onsite and offsite. All staff who work in the dementia unit hold recognised New Zealand Qualification Authority certificates.   The service implements staffing levels and skill mixes that meet contractual requirements as identified in policy. |

|  |
| --- |
| **Outcome 1.3: Continuum of Service Delivery** |
| The residents and family interviewed express satisfaction with the care and services provided at Edenvale Rest Home. The service meets the requirements and timeframes for assessment, care plan development, review, evaluation and the provision of care. The care is regularly evaluated to ensure the residents’ assessed needs and desired outcomes are being met.   The service provides planned activities for all age groups and acuity levels and residents are fully involved in this process to ensure what is offered is meaningful to the resident and allows them to maintain or improve their strengths, skills and interests. The residents and families interviewed report that the activities programme is one of the strengths of the service.   Residents receive medicines in a safe and timely manner. Staff who undertake medicine administration hold appropriate competencies. There is one area requiring improvement to ensure that all medications that are administered are signed for on the medicine signing sheet.   The food services are provided by a contracted catering company. The food is prepared and cooked at Edenvale Rest Home. Residents are provided with food, fluid and nutritional services that are assessed by a qualified dietitian as being suitable to meet all nutritional needs. This includes additional or modified nutritional requirements and residents’ likes and dislikes. |

|  |
| --- |
| **Outcome 1.4: Safe and Appropriate Environment** |
| The facility has an up to date building warrant of fitness. |

|  |
| --- |
| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. There is a process for determining restraint approval and ongoing education and competencies for staff. Currently the service only has environmental restraint in place which is fully described in policy and appropriate documentation is completed, including family/whanau approval. |

|  |
| --- |
| **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**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 14 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 2 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 62 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.13: Complaints Management | The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.13.3 |  | PA Low | In the February 2014 staff meeting minutes a complaint is discussed and resolution is shown but this does not appear in the complaints folder which is used as a register. This was discussed with the manager at the time of audit. | Ensure all complaints are shown in an up to date complaints register which identifies dates, and actions taken. | 180 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Six of the 12 medicine signing sheets sighted have at least one time when medication has not been signed as given. | Ensure all medicines given are signed as given on the medicine signing sheet, or reason for not giving the medication recorded. | 180 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents have a right to full and frank information and open disclosure from service providers. The five of five residents’ files (two rest home, one hospital, two dementia unit) and incident reports sighted evidence open disclosure. The four of four care staff interviewed (one RN, one EN and two nurse aids) demonstrate knowledge of open disclosure. The four of four residents (three rest home and one hospital) and three of three family/whanau report they are fully informed.   Wherever necessary and reasonably practicable, interpreter services are provided. The clinical leader who is a registered nurse (RN) reports that all residents speak English and there are no residents who require an interpreter. If an interpreter is required, this can be accessed through the national interpreters service or the district health board (DHB).   The Aged Related Residential Care (ARRC) service agreement requirements are met. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service ensures that residents, family/whānau and visitors have easy access to complaints forms which are available at the entrance to the facility. The complaints process is discussed as part of the admission process. Interviews with four of four residents (one hospital and three rest home), three of three family/whānau members and seven of seven staff (one administrator, two nurse aids, one maintenance officer, one RN, one enrolled nurse (EN) and the activities coordinator) confirm they understand the complaints process.  Organisational policy and procedures clearly set out how complaints management is undertaken. There is a complaints folder in use which is used as a register to show actions taken related to complaints but not all complaints information is identified. This is an area identified for improvement.   As confirmed by the manager, at the time of audit there are no outstanding complaints. Complaints management is used as a means to improve service delivery where applicable. |

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Staff, residents and family/whanau confirm they understand the complaints process. The service has a complaints folder which has complaints information related to two complaints received over the past 12 months. One is of a minor nature and one of a serious nature which resulted in several family/whanau meetings, disciplinary action against a staff member, Board of Trustee (BOT) involvement and then close off.  In the February 2014 staff meeting minutes a complaint is discussed and resolution is shown but this does not appear in the complaints folder which is used as a register. This was discussed with the manager at the time of audit. |
| **Finding:** |
| In the February 2014 staff meeting minutes a complaint is discussed and resolution is shown but this does not appear in the complaints folder which is used as a register. This was discussed with the manager at the time of audit. |
| **Corrective Action:** |
| Ensure all complaints are shown in an up to date complaints register which identifies dates, and actions taken. |
| **Timeframe (days):** 180 *(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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisation's purpose, values, scope, direction and goals are identified in the business plan which covers all aspects of service delivery. Objectives, actions and responsibility are well set out. The business plan is supported by a quality plan and a risk plan and analysis and review is undertaken at least two yearly to ensure services are planned, coordinated and appropriate to meet the needs of consumers. All objectives are approved at the Board of Trustees (BOT) level.  The day to day operations of all services is overseen by the manager who has held the position for 14 years and she is supported by a registered nurse (RN) who is the clinical leader. Both staff are suitably qualified and experienced and undertake management responsibilities as shown in their job descriptions. The job descriptions identify their authority, accountabilities and responsibilities.  Interviews with three of three family/whānau members and four of four residents (one hospital and three rest home) confirm they are very happy with the services provided and that their needs 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.

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The organisation has quality and risk management systems in place which include a regular audit schedule covering all aspects of service delivery. Any deficits identified are addressed via the use of corrective action planning. One example relates to the documentation audit which identified that staff were not utilising short term care plans to meet policy requirement. This was discussed at the RN meeting and further education was provided. The re-audit identifies this is now being fully implemented as sighted in five of five resident file reviews.  Interviews with seven of seven staff confirm they understand and implement all required corrective actions which are overseen by the quality and risk monitoring group (QRM) every quarter. This is confirmed in meeting minutes sighted. Monthly staff meetings have a set agenda which identifies that key components of service delivery are discussed, including quality and risk issues.  There is a system implemented to ensure policies and procedures are aligned with current good practice and service delivery which meet the legislative requirements and that two yearly reviews are maintained. The manager reports that policies are changed sooner to meet any changes to best practice or legislation. All policies and procedures sighted on the day of audit are current.   Key components of service delivery are linked to the quality management systems. This is achieved via monthly reports from all areas, including management, nursing, administration and maintenance, being provided to the manager who reviews the reports and tables them quarterly at the QRM group meetings. The QRM group, which has a representative from all areas of service on it, then monitors any corrective actions required. One example sighted relates to the introduction of a newly devised behavioural chart which better identifies the diversional techniques used by staff to de-escalate residents when required. QRM meeting minutes show that the chart is being correctly utilised by staff and better data capture has been obtained. This is confirmed during review of two charts in the dementia care area and by staff interviews.  The QRM formally report to the Board of Trustees quarterly on health and safety, restraint use, complaints, infection control, education, staffing, hazards, future planning, current and future projects, occupancy, maintenance, and finance matters. This is identified in the BOT meeting minutes sighted. The reports are supported by statistical data which is collected, collated, analysed and evaluated to identify any areas that may require corrective actions. This data is also shown on graphs for ease of review.  The service benchmarks against previously collected data to make sure services are being delivered to an expected standard.   Corrective actions sighted cover all aspects of service delivery and information is gathered from many sources, such as audits, complaints, incidents and accidents, infection control data, health and safety. All corrective actions are signed off by the manager upon completion.  Resident and family/whānau are surveyed annually to obtain feedback on service provision and results sighted show that there are no areas of concern from the 2014 satisfaction surveys. This is supported by four of four residents and three of three family/whānau interviews from which there were no negative comments.   Actual and potential risks are identified in the business plan and the service has an up to date hazard register which identifies environmental hazards. As confirmed by the manager, all risks are reviewed annually at management and BOT level. If a risk has been eliminated, it is shown how this occurred, or it is shown how it is isolated or eliminated. Interviews with seven of seven staff and two members of management confirm they are aware of and implement the hazard reporting process as described in policy. |

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

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

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

##### **Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| As identified in policy and confirmed during interview with the manager, the organisation’s obligations related to essential notification reporting to the correct authority is clearly understood and implemented as required.   Policy and procedure is in place to indicate that all adverse, unplanned, or untoward events are reported, recorded on incident and accident forms. A review of incidents and accident forms identifies that family/whānau are notified. This is monitored by the clinical leader and the manager. This was an area identified for improvement in the previous audit and is now fully attained. Information from incident and accident forms are used to identify any shortfalls in service delivery and used as an opportunity to improve services or identify risks.   Incident and accident monthly reports are generated from information gathered. This includes specific data related to falls with and without injury, aggression, abuse, ‘wandering’ and medication errors. This data informs the quality report and is benchmarked against previously collected data. Any areas identified for improvement are written up as corrective actions. One example relates to the purchase and use of more sensor monitoring alarm mats for residents who tend not to use the call bell to request assistance. This is confirmed by clinical staff interviews and observations made on the day of audit. This data is presented at staff, management and BOT. meetings as appropriate.   Family/whānau interviews indicate that they are kept well informed of any adverse event or concerns staff may have related to their relative. |

##### **Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)**

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Human resources management processes are implemented to meet legislative and good practice requirements as described in organisational policy. Five of five staff record reviews identify that staff are employed to undertake roles appropriate to their skills and knowledge. Reference, credential and police checks are completed for all newly appointed staff. Practising certificates are sighted and a copy is held in the staff member’s file. Annual practising certificates are sighted for one enrolled nurse, 15 pharmacists and the pharmacy licence to operate, three GPs, one podiatrist, seven RNs and one physiotherapist.   The service ensures all new staff orientation/induction processes are undertaken to enable staff to meet the needs of residents. This is supported by interviews undertaken with two recently appointed staff and in documentation sighted in staff files. Only staff that have recognised dementia care qualifications work within the secure dementia care area. The manager reports that when employing she looks at past experiences or ability of new staff that are willing to complete appropriate education and training.   There is a process in place to identify relevant training requirements for staff with a clearly documented ongoing education plan and regular review of staff competencies to ensure safe practice delivery. Education includes first aid, New Zealand Qualifications Authority approved education related to aged care and specialised dementia care, emergency management, and all aspects of day to day management of residents. Staff report they have access to off-site education such as end of life care and infection control. In service education is presented in modules covering occupational health and safety, compliance requirements, infection control, nursing cares and documentation, general nursing cares and use of equipment. These are presented regularly so all aspects of service delivery is covered over a two year rotating period. Attendance records sighted show that there is very good attendance at in-service training/education. Attendance is monitored by the manager and is discussed at annual performance reviews which are all up to date.   Interviews with four of four residents and three of three family/whānau members confirm the services offered are delivered in a safe and effective manner to meet their needs. This is supported by the 2014 resident and family/whanau satisfaction survey results sighted. |

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

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

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents receive timely, appropriate and safe service from suitably qualified, experienced service providers. Clinical services are overseen by a clinical leader who is a RN. A review of the roster identifies that all shifts have a staff member who holds a current first aid certificate and a RN. Staffing levels and skill mix are maintained to meet contractual requirements as set out in policy. If the work load increases owing to issues such as end of life care, staff and management confirm additional staff are put on duty.   The roster review also identifies that there is dedicated staff with appropriate qualifications in the secure dementia unit at all times. Activities are offered six days a week. Cleaning and catering services are contracted.   Staff interviews confirm they have enough time to complete all tasks. Resident and family/whānau interviews along with results of the 2014 Consumer Satisfaction survey confirm they are happy with the level of service offered. |

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

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

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

## **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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| 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. The RNs conduct the nursing assessments, review and evaluate the care plans. The care plans are developed by the RNs with input from other staff, residents and family/whanau. The nurse aids who work in the specialist dementia unit have the required national unit standards in dementia care. The GPs conduct the medical assessments and reviews. Current practising certificates are sighted for all staff that require them.  The service has commenced the electronic interRAI assessment tools and is in the process of reviewing a suitable electronic system for the care planning. The service is working towards developing a fully electronic process for resident records. The current paper based initial assessments covers the physical, emotional, social, cultural and spiritual needs of the resident. If the initial assessment has been completed using the interRAI assessment, this is printed and placed in the resident’s paper based file. There is an initial care plan used for up to three weeks until the long term care plan is developed. The service utilises a standardised long term care plan which is individualised to the resident’s needs, their own individual long term care plan for other identified needs and short term care plan for temporary changes. The long term care plans identify the issue, nursing objectives, carer actions and the evaluation of care. The needs identified on the long term care plan include assistance with personal care agreed with the resident (and where applicable the family), and address the needs identified through the assessment process. The long term care plans record those who are consulted to contribute to the care planning (eg, resident, family, staff, key worker, diversional therapist, occupational therapist and physiotherapist). The five of five residents’ files reviewed (two dementia unit, one hospital and two rest home level of care) have the appropriate assessments, care plans and desired goals identified.   Interview with the clinical leader (RN) confirms that the initial assessment and initial care plan are developed on the day of admission, the long term care plan is developed within three weeks and reviewed and evaluated at least six monthly. The five of five residents’ files reviewed (two rest home, two dementia and one hospital) have the initial review by the GP within two days of admission. The four of four residents interviewed (one hospital and three rest home) report a high satisfaction with the medical coverage and feel they are able to access the GP when they require their services.   Each resident has one file which includes the multidisciplinary team input into care. There is a verbal handover between each shift. A communication book is also maintained to record appointments. The one RN, one EN and two nurse aids report that there is an adequate handover to provide information for the continuity of care and report an excellent team approach to care  Tracer example one, dementia level of care.  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer example two, hospital level of care.  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer example three, rest home level of care.  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.

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The provision of services and/or interventions are consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes. The service has adequate dressing and continence supplies to meet the needs of the residents. The five of five care plans reviewed (two rest home, one hospital and two dementia), record interventions that are consistent with the residents' assessed needs and desired goals. Observations on the day of audit indicate residents are receiving care that is consistent with their needs. The four of four residents and three of three family/whanau interviewed report that the service meets the needs of the residents. The file of one resident living in the dementia unit has interventions for the resident’s challenging behaviours. The hospital resident reviewed has the intervention for mobility changed to reflect the resident’s changed needs. The interventions put in place to meet residents' needs are monitored by staff.   The four of four residents (three rest home and one hospital) and three of three family/whanau have high praise for the interventions at the service.   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.

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the resident. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The activities coordinator reports that activities are developed to maintain residents’ skills and strengths for the rest home, hospital and residents living in the dementia unit. The programmes include reminiscing, storytelling, gardening, cooking, music therapy, exercise and art. The activities may involve dance, movement or quiet time in conversation based on the personalised needs of the residents.   Seasonal and topical celebrations are incorporated into the activities programme, such as ‘the royal visit’, sporting occasions and ANZAC Day. The nurse aids and volunteers assist with providing meaningful activities for the residents when the activities co-ordinator is not available. Each resident has an initial assessment completed on admission and a personal profile book is given to the family/whanau to complete. The monthly activity planner is displayed on the notice board. The four of four residents and three of three family report satisfaction with the activities programme. One family member reports that the amount and range of activities is one of the strengths of the service. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Evaluations are documented, resident-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. Nursing reviews and assessments, medical and specialist consultations and admission to hospital for specialist treatment is clearly documented in five of five residents' files reviewed. Four of the five files reviewed have a documented evaluation that is conducted within the past six months, with one of the remaining files of a resident with an admission less than six months and therefore not yet due for the six monthly review.   Evaluations in four residents' files reviewed of residents with admission over six months are documented and have evaluations of the issues in the care plan. These evaluations are resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the desired outcomes.   If a resident is not responding to the services/interventions being delivered, or their health status changes, then this is discussed with their GP. Residents' changing needs are clearly described in seven of seven care plans reviewed. Short term care plans are sighted for wound care, pain, infections, and changes in mobility, changes in food and fluid intake and skin care. These processes are clearly documented on the short term care plan, medical and nursing assessments and the resident's progress notes. The four of four care staff interviewed (one RN, one EN and two nurse aids) demonstrate good knowledge of short term care plans and report that these are identified at handover.   The four of four residents and three of three family/whanau report that they can consult with the staff at any time if they have concerns or there are changes in the resident's condition.   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.

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service uses robotic packaging systems supplied in the robotic sachet. Administration practices were observed for a lunch time medicine administration which evidence good practices are followed in accordance with organisational policies. There is a list of specimen signatures on each signing sheet. Information is provided by the pharmacy for specific instructions (eg, crushing) and health professional information is easily accessible to staff administering medicines. The sample of the medicine files reviewed is increased to 12 files to further review the signing sheets that record when the medications are given. This is an area for required improvement and refers to criterion 1.3.12.6.   Reconciliation processes have been initiated, with RN responsibility determined on delivery each month. The GP conducts medicine reconciliation when residents are admitted to the service and when residents are discharged from the acute care hospital. The 12 of 12 medicine files reviewed are consistently completed for signing of the medicine order, discontinuations signed and dated. The three monthly medicine reviews are recorded by the GP on the 12 of 12 medicine charts reviewed.  Packaged medicines are supplied in robotic packs, non-packed individual supplies and prescribed controlled drugs are individually prescribed. There are processes in place to rotate the stored medicines to ensure they do not expire.   Service providers responsible for medicine management are competent to perform the function for each stage they manage.  There is facilitation of safe self-administration of medicines by residents where appropriate. The RN reports that self-administration of medicines is not appropriate for the cognitively impaired residents. There are no residents who self-administer their medicines at the time of audit.  Medication management records sighted use the pharmacy generated record and signing sheets for robotic sachets. There are additional signing sheets for non-packed items such as prednisone, PRN medicines, and short courses, such as antibiotics, and warfarin and insulin. Up to date photos are sighted in the 12 of 12 medicine files reviewed and details of the preferred method of administration are on file for each resident. |

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Medicine management information is not fully recorded to a level of detail to comply with legislation and guidelines. Six of the 12 medicine signing sheets reviewed have at least one time when the medication is not signed as given or the reason for not giving the medication is not recorded (eg, resident refused). The clinical leader at the time of audit noted that it was one staff member that has been inconsistent with the recordings on the signing sheets and has commenced actions to address the inconsistency. A corrective action request is made to ensure all medications that are administered are signed as given. |
| **Finding:** |
| Six of the 12 medicine signing sheets sighted have at least one time when medication has not been signed as given. |
| **Corrective Action:** |
| Ensure all medicines given are signed as given on the medicine signing sheet, or reason for not giving the medication recorded. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Food services are contracted to an external catering service. They have their own policies and procedures which ensure their staff work within recognised food and nutritional guidelines. The catering service works with a registered dietitian who ensures the nutritional needs of residents are provided as appropriate for the aged care environment. A review of the current menu is last conducted November 2013.   There is a process in place which identifies residents' additional and/or modified nutritional requirements or special diets. The chef maintains a white board in the kitchen which clearly shows who has pureed food, who requires additional milkshake dietary supplements and who is on a high protein diet. One resident with a food allergy has this clearly identified via the use of a white board and a red sticker.   As confirmed during interview with four of four residents and three of three family/whanau members, they are very happy with the food and that all their needs, likes, dislikes are met.  The external catering service cooks and prepares the food at Edenvale. The catering service ensures all aspects of food procurement, production, preparation, storage and transportation meets current legislation and guidelines. The chef stated that three monthly audits are undertaken by the catering service and corrective actions are put in place as required to ensure compliance continues. Daily food temperatures, chiller and freezer temperatures meet required standards as sighted. There is a cleaning schedule in place which is carried out by the contracted cleaners. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a current building warrant of fitness which expires on 30 September 2014. All actions are taken to ensure legislative compliance is maintained. There have been changes to the application to service levels with hospital level care being introduced since the previous audit but bed numbers and the facility footprint has remained the same as in previous audits. |

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

All buildings, plant, and equipment comply with legislation.

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

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Policy identifies that enablers are voluntary and the least restrictive option to meet the needs of residents to promote or maintain independence and safety. There are no enablers in use at the time of audit.   The restraint register identifies that the service has environmental restraint in use for three residents who have a degree of dementia and tend to wander. This is fully described in policy and all three residents have completed assessment to verify the appropriate use of them not having the access code to the front door. They are all rest home level care residents. Family/whānau signoff sighted in all three files.   The register also shows that there are nine residents in the secure dementia unit who have locks on their bedroom doors which are only used to secure belongings and used during the day. Staff confirm that if the resident wishes to enter their bedroom at any time during the day they open the door for them. A discussion was held with the restraint coordinator (clinical leader) and the manager around this not being restraint in the true sense as resident movement is not restricted. It was agreed that this would be taken to the QRM meeting for review. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection prevention and control programme and organisational policy details surveillance processes, including the surveillance objectives, priorities and methods at a level of detail relevant to the service setting and its complexity. Monthly surveillance is conducted on infections and reported to the staff and manager. There is three monthly benchmarking with an external infection control consultancy service.   Monthly data collection of infections is conducted and reported on individual infection control reports. The infection control officer's evaluation of the infection control data is fedback through the quality and risk meeting. The benchmarking report from the quarter ending December 2013 records an overall reduction in infections compared to the same time the previous year. The analysis of the monthly surveillance data by the infection control officer indicates for 2014 there are overall low infection rates in the rest home and dementia units in January, February and March 2014. The hospital records an overall increase in infections per 1000 occupied bed days from 8.7 in January and increased to 19.9 in February 2014. The analysis records there is an increase in urinary tract infections (UTIs). The infection control coordinator reports that to decrease the UTIs for the hospital residents, the staff are encouraged to provide residents with greater amounts of fluids, and reinforcing of hygiene practices occurred. The number of infections in the rest home reduced to 5.8 infections per 1000 bed days in March 2014. |

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

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

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

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

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

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