# Nicolson Rest Home Limited

## Current Status: 13 February 2014

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

## General overview

Irwell trading as Nicolson Rest Home Limited is a 60-bed rest home with 38 rooms on the ground floor and 22 rooms on the first floor. All rooms have ensuites. The facility is a family owned and operated business since 1998. Residents and relative interviewed on the day of audit were very complimentary about the management and staff, the care, and the environment.

The two shortfalls identified at their previous audit relating to electrical checks and corrective actions has been addressed.

This audit identified areas for improvement relating to the complaints register, clinical internal audits and registered nurse appraisal.

## Audit Summary as at 13 February 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | 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 13 February 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Organisational Management as at 13 February 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Continuum of Service Delivery as at 13 February 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 13 February 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 13 February 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 13 February 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

|  |  |
| --- | --- |
| **Legal entity name:** | Nicolson Rest Home Limited |
| **Certificate name:** | Nicolson Rest Home Limited |

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| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Irwell Rest Home | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 13 February 2014 | **End date:** | 13 February 2014 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 49 |

## Audit Team

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 5 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## Sample Totals

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 11 | Total audit hours | 27 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 7 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 33 | Number of relatives interviewed | 4 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## Declaration

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

I confirm that:

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

Dated Friday, 28 March 2014

## Executive Summary of Audit

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| **General Overview** |
| Irwell trading as Nicolson Rest Home Limited is a 60-bed rest home with 38 rooms on the ground floor and 22 rooms on the first floor. All rooms have ensuites. The facility is a family owned and operated business since 1998. Residents and relative interviewed on the day of audit were very complimentary about the management and staff, the care, and the environment.  The two shortfalls identified at their previous audit relating to electrical checks and corrective actions has been addressed.  This audit identified areas for improvement relating to the complaints register, clinical internal audits and registered nurse appraisal. |

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| **Outcome 1.1: Consumer Rights** |
| Management have an “open door “policy. Residents and relatives interviewed state the management and staff are very approachable should they have any concerns and are aware of the complaints process. The residents have access to advocacy services. Residents meetings are held monthly providing an opportunity to feedback on the services and receive information/updates on services, the environment, community events and activities. Families interviewed state they are always made to feel welcome and are kept informed in matters that affect their relative’s lives.  There is a complaints policy supporting practice however, there is an improvement required to maintain an up to date register. |

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| **Outcome 1.2: Organisational Management** |
| The organisation has an annual business and risk management plan in place with quality objectives that are linked to the quality improvement system. The service has implemented policies and procedures. Quality, health and safety and infection control are set agenda items at the quality improvement meetings and staff meetings. There is an improvement required around clinical audits. Staff interviewed confirmed they are kept informed on risk management matters and receive meeting minutes and graphs. Newly employed staff complete an orientation programme. There is an education planner in place that includes compulsory training for aged care staff. There is an improvement required around an annual appraisal for the full-time registered nurse (RN).  There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. The staffing roster indicates there are adequate numbers of staff on duty to safely deliver care within a timely manner. There are two RNs employed. The full-time RN is available on call. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Care plans are developed by the nurse manager who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. Residents and family members interviewed state that they are kept involved and informed about the resident's care. The medication management system includes medication policy and procedures that follows recognised standards. Staff responsible for medication administration are trained and monitored. Resident medications are reviewed by the residents’ general practitioner at least three monthly. A range of activities are available and residents provide feedback on the programme.  Irwell Rest Home has food policies/procedures for food services and menu planning appropriate for this type of service. Food safety in-service is completed by staff, dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The service has a current building warrant of fitness, which expires 23 November 2014. There is a compliance certificate for the Person-carrying-lift which expires 18 November 2014. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are comprehensive policies and procedures that meet the restraint standards. The registered nurse is the restraints co-ordinator and provides a report to the quality committee meeting three monthly. The service currently has no residents on restraint or enablers. |

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| **Outcome 3: Infection Prevention and Control** |
| The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The registered nurse is the infection control co-ordinator. The Infection Control co-ordinator is part of the quality committee group. Reports and surveillance data are discussed at staff meetings. All staff receive infection control education on orientation and attend annual education. |

## Summary of Attainment

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 13 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 3 | 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 | 5 | 0 | 29 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 8 | 0 | 52 |

## 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 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | There is one written and one verbal concern recorded in the communication book that has not been addressed or included in the complaints register. | Ensure all concerns/complaints are addressed within the required timeframes and entered into the complaints register. | 90 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.8 | A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Clinical audits have not been undertaken by a clinical person for the last six months. | Ensure clinical audits are undertaken by a clinical person. | 90 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.2 | Professional qualifications are validated, including evidence of registration and scope of practice for service providers. | PA Low | The senior RN does not have an appraisal. | Ensure an annual appraisal is completed for the senior RN. | 60 |

## Continuous Improvement (CI) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## Outcome 1.1: Consumer Rights

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The management promote an “open door” policy. Relatives are aware of the open door policy and confirm on interview that the staff and management are approachable and available. The owners live on site and are available to meet with residents and families after hours if required. The registered nurse (RN) is available on call to discuss and clinical concerns the family may have. Information is provided in formats suitable for the consumer and their family. There is a residents meeting held monthly with opportunity for feedback on the services. The activity officer and one other staff member takes the meeting. The residents have an advocate from elder support attend the meetings. Topical and informative newsletters go out to the residents and families. Annual resident, relative and food satisfaction surveys are completed that provide feedback on all areas of the service. Twenty-one staff attended code of rights training October 2013. Staff complete a self-directed questionnaire on effective communication.   D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. Four relatives and five residents interviewed stated they were given sufficient information prior to entry to the service and had the opportunity to discuss information and the admission agreement with management. There is an information pack available for short-term residents.  D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D16.4b Four relatives stated that they are always informed when their family member’s health status changes (link 1.2.4.3). D11.3 The information pack is available in large print and advised that this can be read to residents. Interpreter services are available as required. |

##### 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:** PA Low |
| **Evidence:** |
| The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. The RN is involved in clinical investigations as necessary. There is evidence of one verbal concern regarding a call bell that was not functioning. Immediate action was taken to ensure all call bells were working. The call bell was found to be tangled and not plugged in. Staff were made aware of the concern (as documented in staff meeting minutes) and a plan is in place for all call bells to be checked after the morning and afternoon shifts. There is letter of acknowledgment and outcome of the investigation sent to the complainant. There is one written and one verbal concern recorded in the communication that has not been addressed or included in the complaints register. Where appropriate surveys or internal auditing is completed as part of the monitoring process. Concerns/compliments and complaints forms are available to residents and family/visitors to the facility. Staff interviewed are knowledgeable in the complaints and concerns process.  D13.3h. A complaints procedure is provided to residents within the information pack at entry. Outcomes of the concerns/complaints are discussed at the management and staff meetings. Discussion with five residents and four relatives confirmed they were provided with information on complaints and complaints forms and are comfortable approaching management with any concerns/complaints. |

##### 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:** PA Low |
| **Evidence:** |
| There is evidence of one verbal concern regarding a call bell that was not functioning. Immediate action was taken to ensure all call bells were working. The call bell was found to be tangled and not plugged in. Staff were made aware of the concern (as documented in staff meeting minutes) and a plan is in place for all call bells to be checked after the morning and afternoon shifts. There is letter of acknowledgment and outcome of the investigation sent to the complainant. |
| **Finding:** |
| There is one written and one verbal concern recorded in the communication book that has not been addressed or included in the complaints register. |
| **Corrective Action:** |
| Ensure all concerns/complaints are addressed within the required timeframes and entered into the complaints register. |
| **Timeframe (days):** 90 *(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:** |
| Irwell trading as Nicolson Rest Home Limited is a 60-bed rest home. On the day of audit, there are 49 rest home residents. The service provides respite care. The facility is a family owned and operated business since 1998. The service is managed by the experienced husband and wife team (owner/operators and directors) who live on site. The owner/operators are supported by an experienced registered nurse (RN) who provides on call 24 hours a day. A second RN has been employed part-time to provide additional clinical support and cover for leave. The 2013 business plan incorporates the risk management plan and goals for each area of service delivery and organisational management. The annual business-planning meeting is scheduled for April 2014 to evaluate the 2013 goals and sign off the 2014 business/risk management plan. Business goals achieved for 2013 included (but not limited to); refurbishment of bedrooms (curtains and wallpaper), re-carpeting of two bedrooms, painting of external building and re-cladding of parts of the building, landscaping of gardens and purchase of new chair scales. There are on-going plans for refurbishment and purchase of lounge furniture for 2014. The owner/operators are responsible for the operational and financial aspect of the business.  The owner/directors are qualified caregivers who have maintained at least eight hours of management training per year. The business is a member of the N.Z. Aged Care Association and attend provider meetings and district health board forums providing networking opportunities.  The service strives to achieve the organisational mission statement “Caring for the elderly in a family environment”. For relatives and five residents stated on interview that the environment is homely and the staff are caring and respectful. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are organisational policies to guide the facility to implement the quality/risk management programme including (but not limited to); quality assurance and risk management programme, quality improvement committee responsibilities and internal audit schedule. Quality improvement committee meetings are held monthly and cover matters arising from the staff and resident meetings, policy reviews, concerns, accidents and incidents and infection control, internal audits and outcomes. The quality improvement committee meeting representatives include the directors/privacy officer, RN/infection control co-ordinator, restraints co-ordinator, shift leader and administrator. Internal audit results are discussed.  An agenda is for the staff meeting is made available for staff input prior to the meeting. Minutes sighted evidence there is discussion around concerns, compliments, health and safety, infection control, audit and survey results and improvements. Infection control and accident/accident graphs are displayed in staff areas.  Seven staff interviewed state they are well informed and receive quality and risk management information including accident incident graphs and infection control stats.   Clinical guidelines are in place to assist care staff with such issues as incontinence, challenging behaviour, falls prevention, nutrition and hydration, skin care and wound management and pain management. There is an annual staff-training programme that is implemented and based around policies and procedures. Internal audits are completed for (but not limited to); clinical documentation (care plans), restraints policy audit, promotion of continence, handover sheets, medication, food services, hand washing, cleaning service, food services and chemical storage confidentiality. Clinical audits have not been undertaken by a clinical person for the last six months.   D5.4 The service has the appropriate policies and procedures to support service delivery.  D19.3: There is a Quality and Risk management programme in place that includes health and safety and hazard identification. There is a hazard register for specific hazards and controls for all communal areas, resident bedrooms, environment (lifts, stairs, security and vehicles), and kitchen and laundry areas.  D19.2g. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Prevention strategies and corrective actions is documented in the residents care plan. Their service utilises the accident compensation corporation (ACC) falls prevention programme. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Internal audits are completed for (but not limited to); clinical documentation (care plans), restraints policy audit, promotion of continence, handover sheets, medication, food services, hand washing, cleaning service, food services and chemical storage confidentiality. |
| **Finding:** |
| Clinical audits have not been undertaken by a clinical person for the last six months. |
| **Corrective Action:** |
| Ensure clinical audits are undertaken by a clinical person. |
| **Timeframe (days):** 90 *(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:** |
| As part of risk management and health and safety framework, there is an accident/incident policy, which includes reference to open disclosure, level of seriousness and the responsibility for investigation, corrective actions and quality improvements. There is evidence of month-by-month data collection including (but not limited to): falls, skin tears, medication, behavioural incidents and near misses. Falls management and prevention includes monthly analysis of all accidents/incidents. Data is entered into the online database from which graphs are produced. When an incident occurs the staff member discovering the incident completes the accident/incident form. The incident/accident is documented in the progress notes. Interventions and monitoring requirements are linked to the long-term care plan. Data is entered into the online system for individual incidents/accidents that documents RN input and assessment. Reports are attached to the incident/accidents forms to evidence RN sign off on the accident/incident forms (corrected on day of audit). There is open disclosure practiced. Four family members interviewed state they are informed of incidents/accidents. Monthly data is taken to the quality improvement management committee meeting and staff meetings. The three caregivers interviewed could describe the process for reporting of incidents and accidents.  D19.3b; There is an accident/incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action.  D19.3c The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. |

##### 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:** PA Low |
| **Evidence:** |
| There are human resources policies including recruitment, selection, orientation and staff training and development. Six staff files reviewed are; two RN’s, two caregivers, one cook and one cleaner.  The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and suitability for the role. The two RNs have current practicing certificates. Six of six staff files sampled evidenced reference checks, employment agreements and orientations. The senior RN does not have an appraisal.    There is an orientation programme that includes organisational structure and policies and general information for staff. Staff are orientated to their area of work and complete competencies relevant to their role. Staff turnover is low. Vacancies are generally due to caregivers taking on university studies. The most recent recruitment in January 2014 (caregiver) is in the process of completing the orientation package.   There is a 2013 documented in-service programme for education that covered compulsory requirements including (but not limited to) standard precautions (April – 15 staff), Fire training (May), diet and nutrition (March – 18 staff), medication administration (June – 14 staff), privacy and dignity (June – 20 staff), Safe food handling (July – 23 staff), chemical safety (July – 22 staff), code of rights (October – 21 staff), Treaty questionnaire (22 staff). There is a mix of speakers, internal trainers and self-directed questionnaires completed as part of the education programme. Staff are supported to complete career force training with on-site assessments.  to undertake external education. There is an education programme for 2014 that commences in February 2014.  D17.8 Eight hours of staff development or in-service education has been provided annually. |

##### 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:** PA Low |
| **Evidence:** |
| The two RNs have current practicing certificates. Six of six staff files sampled evidenced reference checks, employment agreements and orientations. |
| **Finding:** |
| The senior RN does not have an appraisal. |
| **Corrective Action:** |
| Ensure an annual appraisal is completed for the senior RN. |
| **Timeframe (days):** 60 *(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):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Staffing rosters were sighted and there are an adequate number of staff on duty to meet the resident’s needs on different shifts and for both floors of the facility. The (owner/directors) are both qualified caregivers, live on site and are available on call. There are five caregivers on morning shift with two finishing at 1400. There are two caregivers on the full afternoon shift and three on the short afternoon shift. There are two caregivers on nightshift. The senior RN works Monday to Friday and a part-time RN two days per week providing RN cover six days a week and on call 24/7. There is a senior caregiver (shift leader) on Monday to Friday whose responsibility is administering medications, supporting the care team and assisting the RN.  There is a staff workload monitoring policy, which takes the acuity of residents into consideration when determining staff numbers on duty. Five residents interviewed confirm that there are sufficient staff on site at all times and staff are approachable and in their opinion, competent, professional, respectful and friendly. |

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

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

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Five resident files were reviewed. An initial assessment and the beginning of the development of the resident's care plan occurs during admission and a general practitioner (GP) assessment occurs within 48 hours. The long-term care plan is developed within three weeks of admission and evaluated every six months or when indicated due to a change in resident condition. Family/whānau are kept informed about the resident's care. Communication with family is documented on a family contact sheet. Caregivers complete progress notes on every shift. There is an appropriate hand-over briefing between shifts that staff are able to describe. The initial assessment occurring within 24 hours includes: a) resident information/details, b) hygiene requirements, c) sleeping pattern, d) medication, e) elimination, f) communication, g) mobility, h) aids, i) eating & drinking, and j) spirituality. A general practitioner assessment occurs within 24 hours of admission.  The long-term care plan is developed within three weeks of admission and evaluated every six months or when indicated due to a change in resident condition. Initial assessment and care plans are developed by the registered nurse. Care includes assessment, planning, provision, evaluation, review and exit and is developed with the resident, and where appropriate their family/whanau of choice or other representative/s. Communication with family is documented. There was evidence of resident and/or family (where appropriate) discussion regarding care needs in all five resident files reviewed. Five relatives interviewed stated they were involved in developing the care plan and also when they review care plans.  Tracer Methodology:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are two registered nurses employed at Irwell covering six days of the week and on call 24/7. A record of all health practitioners practicing certificates is kept. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse. The service being provided is consistent with the needs of residents as demonstrated on the overview of the care plans and discussion with three care givers, one registered nurse, five residents, five families, general practitioner and two management. Five of five care plans are goal orientated and reviewed at six monthly intervals and more frequently if required. During the tour of facility, it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation.  Short-term care plans are in use for changes in health status (link #1.3.8)  All falls are reported on the resident accident/incident form and reported to the registered nurse. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral can be initiated as required.  Three caregivers interviewed stated that they have all the equipment referred to in care plans and necessary to provide care: including hoist, wheelchairs, lifting belts, continence supplies, dressing supplies and any miscellaneous items. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Continence management in-service and wound management in-service have been provided.  There are wound care assessments and management plans in place for eight residents with wounds. One wound is related to preventing a pressure area developing. All wounds have evaluations and progress documented.  The registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The activities programme occurs Monday to Friday for a total of 37.5 hours a week. The activities coordinator works four days and the fifth day is covered by a second activities person. The programme is developed monthly with weekly plans on display. A range of activities are available and these include the involvement of the residents into the community. The programme reflects resident’s interest in the environment and they have choice in their level of participation. One-to-one support is provided in situations where residents are unable to participate in group activities. An activities assessment form is completed on admission and includes resident’s skills, interests and involvements in community activities. Activities care plan includes; a) preferred activities, b) goals and objectives for physical, sensory, cognitive / intellectual and social, religious / spiritual / cultural, and c) suggested individual diversional activities. Attendance record is kept. Five residents interviewed spoke positively of the programme. Activities are regularly evaluated with residents to ensure that the activity programme is real for the residents who currently reside at Irwell. There are monthly resident meetings. The activities coordinator stated at interview that residents are asked frequently to give verbal feedback and asked for suggestions.  D16.5d Five of five resident files reviewed identified that the individual activity plan is reviewed at care plan review time. |

##### 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:** |
| D16.4a Five of five care plans are evaluated six monthly and more frequently when clinically indicated.  D16.3c: All five initial care plans were evaluated by the registered nurse within three weeks of admission.  D16.3k Short-term care plans are in use for changes in health status e.g. chest infections, wounds, and urinary infections. Short-term care plans are evaluated, resolved or added to the long-term care plan if the problem is ongoing.  The GP reviews resident’s medical condition and medication charts every three months. General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out his instructions, giving him full confidence in the care that is being delivered. |

##### 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:** |
| The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID, allergies listed, with three monthly reviews of medication occurring by GP.  Medication charts record prescribed medications by residents’ general practitioners; these are kept in the medication folders. Medication Administration sheets have an identification photo of the individual resident. Signing sheets are in place for packed medication, short term, and prn medication.  The service has adequate information and supervises the self-administration of medicines. Advised that self-administered medications would be securely stored in locked drawers in the resident’s room. Advised there are no residents currently self-medicating.  The service has in place and has implemented systems to ensure, a) residents medicine allergies/sensitivities are known and recorded on the medication sheet, b) adverse reactions and administration errors are identified and appropriate clerical intervention occurs, and c) adverse reactions and administration errors are recorded. Allergies are identified in residents’ medication charts. There is a medication error/mishap assessment form and procedure in place. There is a staff signature identification sheet in the front of the medication folders.  There is a controlled drug register with weekly stock takes by the registered nurse.  All staff performing medication administration receive training on medicine management policies and procedures. Competency testing includes completing a medication workbook, a blood sugar monitoring and pen mix use competency. Training was last provided in June 2013. All staff cover medication administration in their orientation, however they also must complete medication competency before administration of medication is allowed. D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a Food Services manual with policies and procedures that align with current best practice and food safety and hygiene standards. The service has a Certificate of Food Hygiene, which expires 30 June 2014. The service has four-week cyclic summer and winter menus. Dietitian input is obtained. Dietitian involvement was evident for residents with weight loss, including additional supplements. Residents' food preferences are identified and this includes consideration of any particular dietary preferences or needs. Residents with special dietary needs have these needs identified in their care plans and their needs reviewed regularly in the care plan review process. Food is discussed at resident meetings. The cook was able to describe management of special dietary needs. Special equipment is available as required. This includes cups, straws, modified cutlery/crockery etc. The need for supervision, assistance or special equipment is documented in the nutritional assessments and in the resident care plan. Five residents interviewed said they enjoyed their meals and the cook was able to offer alternatives if the required. Four family members interviewed said the quality and variety of meals provided is of a good standard.  Food in the kitchen and storage areas are dated, labelled and rotated. Food in the fridges and freezers are stored correctly, dated and covered. Fridge and freezer temperatures are checked and recorded.  D15.2f: there is evidence that there is additional nutritious snacks available over 24 hours.  D19.2 staff have been trained in safe food handling. |

##### 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:** |
|  |
| **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:** |
| Previous audit required improvement in relation to the service undertaking annual electrical testing, the service has completed this and electrical testing will expire 7 January 2016. This is now met. The service has a current Building Warrant of Fitness, which expires 23 November 2014. Person carrying lift has a compliance certificate expiring 18 November 2014. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

# 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:** |
| There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service currently has no residents on restraint or enablers. |

##### 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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to plan and determine infection control activities, resources and education needs within the facility. Resident infections are collated monthly and include respiratory, urinary, skin and soft tissue, eye infections, diarrhoeal and multi-resistant organisms. There is monitoring of suspected infections that have resolved without antibiotic treatment. A monthly analysis of types of infections, trends, corrective actions and quality initiatives is reported to the quality improvement committee group and to the staff meetings. Surveillance types and numbers are graphed and available to staff (sighted on display in staff areas). |

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