

Presbyterian Support Central - Reevedon

Current Status: 5 May 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

Reevedon rest home is part of the Presbyterian Support Central organisation. The facility provides rest home level care for up to 42 residents. There were 31 rest home residents on the day of audit.

There a comprehensive orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support.

The service has addressed four of the six previous audit findings around accident/accident reports, discontinued medications, chemical safety training and repairs to bathrooms. Two previous shortfalls continue around the closure of internal audits and follow up of resident food concerns.

This audit has identified further improvements regarding staff appraisals, annual review of quality and risk management goals, documentation of clinical interventions and 'as required' medications.

Audit Summary as at 5 May 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

Indicator	Description	Definition
	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 5 May 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 5 May 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.		Some standards applicable to this service partially attained and of low risk.
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Continuum of Service Delivery as at 5 May 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 5 May 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 5 May 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 5 May 2014

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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HealthCERT Aged Residential Care Audit Report (version 4.0)

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:	Presbyterian Support Central
Certificate name:	Presbyterian Support Central - Reevedon
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Reevedon Resthome
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 May 2014 End date: 5 May 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:	31

Audit Team

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

Total audit hours on site	16	Total audit hours off site	11	Total audit hours	27
Number of residents interviewed	5	Number of staff interviewed	8	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	10	Total number of staff (headcount)	25	Number of relatives interviewed	1
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	0

Declaration

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

I confirm that:

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

Dated Tuesday, 17 June 2014

Executive Summary of Audit

General Overview

Reevedon rest home is part of the Presbyterian Support Central organisation. The facility provides rest home level care for up to 42 residents. There were 31 rest home residents on the day of audit including two respite care residents.

There a comprehensive orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support.

The service has addressed four of the six previous audit findings around accident/incident reports, discontinued medications, chemical safety training and repairs to bathrooms. Two previous shortfalls continue around the closure of internal audits and follow up of resident food concerns. This audit has identified further improvements regarding staff appraisals, annual review of quality and risk management goals, documentation of clinical interventions and 'as required' medications.

Outcome 1.1: Consumer Rights

Resident and relative meetings are held approximately two monthly and interviews with residents and the one relative confirm issues raised at meetings are followed up. Family are informed when the resident health status changes. There is a documented process for making complaints and residents, family and staff interviewed are able to discuss the complaints process. Complaints are recorded on an electronic register that includes the complaint, action taken and sign-off.

Outcome 1.2: Organisational Management

Reevedon is part of Presbyterian Support Services and provides rest home care for up to 42 residents. On the day of audit there were 31 residents including two for respite care. While there is an organisational mission statement, vision and values the Quality Programme Plan for Reevedon had not been updated for the current year, and this an area of improvement. Policies are managed centrally. The manager (non-clinical) has been in post for approximately seven weeks and oversees the two Levin Presbyterian facilities and Reevedon has a full time RN Care Manager. These two positions work in partnership to manage Reevedon. Reevedon is implementing the Presbyterian Support Services quality and risk management system that supports the provision of clinical care. Benchmarking is undertaken using the QPS framework. Internal audits are completed, in some cases corrective actions are not recorded as having been closed out. This is an area of improvement recurring from the certification audit. There are human resources policies and an orientation and in-service training programme for new staff. There was a finding against chemical safety training and completion of accident/incident forms from the certification audit and this has now been closed out. Staff files contain appropriate recruitment information however performance appraisals in the files reviewed were not current and this is an area for improvement. The organisational staffing policy aligns with contractual requirements.

Outcome 1.3: Continuum of Service Delivery

The registered nurse is responsible for each stage of service provision. Assessments and support plans are developed and implemented within the required

timeframes to ensure there is safe, timely and appropriate delivery of care.

The residents' needs, interventions, objectives/goals have been identified in the long-term support plans and these are reviewed at least three monthly or earlier if there is a change to health status. There is evidence in the resident files that there is resident and/or family/whanau and multidisciplinary team input into the three monthly reviews. Resident files are integrated and include notes by the GP, nurse practitioner and allied health professionals. An improvement is required around the documentation of interventions to meet the resident's current needs.

The activity programme is resident focused and planned around everyday activities that meet the individual abilities, preferences and choice. Community links are maintained.

Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification and documentation of allergies and sensitivities. The previous shortfall regarding discontinued medications has been addressed. This audit identified an improvement required around the prescribing of 'as required' (prn) medications.

All meals and baking is prepared and cooked off site at another PSC facility located close by. Resident's individual food preferences, dislikes and dietary requirements are met. There is dietitian review and audit of the menus. The previous shortfall around communication between the two facilities regarding menus and resident requirements has been addressed. The previous shortfall relating to the follow up of resident food concerns remains an area for improvement.

Outcome 1.4: Safe and Appropriate Environment

The building has a current building warrant of fitness and fire service evacuation approval. There is a planned maintenance schedule in place. The three toilet/shower areas identified for maintenance and repairs at the previous audit has been addressed.

Outcome 2: Restraint Minimisation and Safe Practice

There are policies and procedures in place is enablers are required. On the day of audit there are no restraints or enablers in use.

Outcome 3: Infection Prevention and Control

There is an infection control policy that included surveillance activities. Infections are reported and collated monthly. Infections and internal audit outcomes are discussed as part of the senior staff meetings and information is available to staff. The surveillance programme is appropriate to the size and complexity of the facility.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	11	0	5	1	0	0
Criteria	0	36	0	5	1	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	33
Criteria	0	0	0	0	0	0	0	59

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.1: Governance	The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low			
HDS(C)S.2008	Criterion 1.2.1.1	The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	The Quality Programme Plan and Risk Management Plan were both dated 2012-2013 and are overdue for review. It is noted these documents appear to cover a calendar year based on the previous versions of the same documents being date 2011-2012.	Update goals for current year.	90
HDS(C)S.2008	Standard 1.2.3:	The organisation has	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Quality And Risk Management Systems	an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.				
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	There continues to be some instances where corrective actions have not been signed off as complete following internal audits and this is a recurring issue from the certification audit.	Corrective actions identified following internal audits are signed out once completed	60
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 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Performance appraisals in five of the five staff files reviewed were overdue for review.	Commence a schedule for updating staff appraisals.	90
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	(i)Five of six wound management plans in place are incomplete. One chronic wound is not linked to the long term care plan. Five out of six wound evaluations/progress notes have not occurred at the required frequency. The pressure area risk and interventions are not documented on the short term care plan. ii) One resident with a nutritional assessment (dated January 2014) score of eight (8) does not have a food and fluid intake chart in place as required. iii) There is no evidence of the monitoring of effectiveness of prn pain relief for resident on controlled drugs. There has not been a review of pain assessment for resident prescribed an increase in pain relief for breakthrough pain.	(i)Ensure wound management plans are completed. Ensure wound evaluations and progress notes are completed within the required timeframe. Ensure chronic wounds are linked to the long term care plans. Ensure pressure area risk and interventions are documented in the care plan. ii) Ensure food and fluid intake charts are commenced as per nutritional assessment score. iii) Ensure pain assessments are reviewed with change to pain management regime. Ensure the effectiveness of pain relief is monitored	60
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	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		practice guidelines.				
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Two out of 10 medication signing sheets do not have indications for use of prn medications.	Ensure prn medications have the indication for use on the medication chart.	60
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.2	Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA Low	Resident meeting minutes September and November 2013 and February 2014 has some discussion around food services. There is no evidence of concerns raised followed up and outcomes communicated to the residents. The previous shortfall remains.	Ensure concerns around food services are followed up.	90

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:

Resident/relative meetings are held approximately two monthly and interviews with residents and the one relative confirm issues raised at meetings are followed up (link 1.3.13). Meeting minutes are available. D16.4b The residents and one relative interviewed inform family are informed when the resident health status changes. The service has policies and procedures available for access to interpreter services and staff interviewed were able to describe the process. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. D11.3 The information pack is available in large print and advised that this can be read to residents.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: FA
Evidence: There is a documented process for making complaints, and the complaints forms were seen available in the facility. Residents, family/whānau and staff interviewed are able to discuss the complaints process, and the one relative interviewed informed concerns are managed effectively and in a timely manner. The facility is moving towards a 'paperless' process for managing complaints and the manager showed the electronic register that includes the complaint, action taken and sign-off. There is reportedly one complaint in process that is being managed by the DHB, otherwise nil of note reported at the time of audit. D13.3h. The complaints procedure is provided to resident/relatives at entry.

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: PA Low
Evidence: Reevedon is part of Presbyterian Support Services and provides rest home care for up to 42 residents. On the day of audit there were 31 residents including two respite. While there is an organisational mission statement, vision and values the Quality Programme Plan for Reevedon had not been updated for the current year and this an area of improvement. Policies are managed centrally. The manager (non-clinical) has been in post for approximately seven weeks and oversees the two Levin

Presbyterian facilities. Reevedon has a full time registered nurse (RN) Care Manager – who had recently joined the team at the time of the certification audit in 2012. These two positions work in partnership to manage Reevedon. ARC,D17.3di (rest home), the manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

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

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

Attainment and Risk: PA Low

Evidence:

Reevedon is part of Presbyterian Support Services and provide rest home care for up to 42 residents with 31 (including 2 respite) on the day of audit. There is a documented mission statement, vision and values for the organisation. There was a Quality Programme Plan and Risk Management Plan in place for Reevedon, however both were dated 2012-2013 and this is an area for improvement. The manager (non-clinical) has been in post for seven weeks and oversees the two Levin facilities. Interview with the manager informs a period of system consolidation is planned going forward. Reevedon has a full-time RN Care Manager. There is and RN on site seven mornings with enrolled nurse (EN) covering the pm shift. In the absence of the Care Manager clinical support can be provided from the other Levin facility which has 24/7 RN cover, and/or the manager. ARC,D17.3di (rest home), the manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

Finding:

The Quality Programme Plan and Risk Management Plan were both dated 2012-2013 and are overdue for review. It is noted these documents appear to cover a calendar year based on the previous versions of the same documents being date 2011-2012.

Corrective Action:

Update goals for current year.

Timeframe (days): 90 (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: PA Low

Evidence:

The Presbyterian Support – Central (PSC) quality framework is in place at Reevedon. Quality goals for the 2013-2014 period are yet to be identified (link 1.2.1); despite this monthly quality data is reported to staff through meetings and to head office where benchmarking is undertaken with reports being available at the facility. The service benchmarking programme identifies key areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk. Policies and procedures are reviewed through the Policy Review Group, and provide a level of assurance that the service is adhering to relevant standards including the Health and Disability Services (Safety) Standards. The quality system incorporates accident/incident reporting and trending, health and safety, complaints, infection control and restraint/enabler use. Service monitoring is completed according to the internal audit schedule, or more frequently if required based on internal audit outcomes. Review of the 2013-2014 internal audits show a small number of identified corrective actions that not signed off as complete and this is a recurring area of improvement from the certification audit. A hazard register is established for all areas of the facility.

D19.3 there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management
D19.2g Falls prevention strategies continue to be developed.

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

Attainment and Risk: PA Low
Evidence: Reevedon is implementing the annual audit programme and the 2013-2014 internal audits were reviewed. Where internal audit results are below the accepted threshold there is a requirement to completed a 're-audit' within a prescribed timeframe and, on the whole this is seen to be completed. Corrective actions are recorded following an internal audit on the audit report. There continues to be some instances where corrective actions have not been signed off as complete and this is a recurring issue from the certification audit. Review of documentation showed there are three forms currently in use – audit report, quality improvement form and quality improvement register. These three forms are completed to varying degrees and may be contributing to the inconsistent corrective action sign out.
Finding: There continues to be some instances where corrective actions have not been signed off as complete following internal audits and this is a recurring issue from the certification audit.
Corrective Action: Corrective actions identified following internal audits are signed out once completed
Timeframe (days): 60 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

Attainment and Risk: FA
Evidence: Interview with the manager and care manager confirm an understanding of reporting requirements to various agencies. D19.3c: There is an incident reporting system in place that includes contact with family following events. This process is moving more towards electronic aggregation of data which reportedly provides more timely information to senior staff. D19.3b; Clinical indicator data is collected. Information is reported through to the senior staff, and Reevedon staff via meetings (minutes sighted), and linked to the organisations benchmarking programme. Trending indicators include: falls, skin tears, bruising, pressure areas, medication errors and challenging behaviour. Staff interviewed are aware of the reporting process for incidents. There was a finding from the certification audit that related to incident forms inconsistently being completed by RN/manager/quality. Review of seven incident forms showed all required information to be completed on forms and the finding from the previous audit is considered to be met.

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Five staff files were reviewed and there was appropriate documentation in all files including job descriptions, employment conditions and supporting recruitment information. Annual practising certificates are sighted for the care manager and enrolled nurse. In all five files reviewed the performance appraisals were overdue and this is an area for improvement. There is an induction process evident in files of recently employed staff and an in-service training programme implemented. Attendance at training is recorded both in individual staff sheets and on a register. A range of training has been provided including compulsory training as identified by PSC. Career force is encouraged for health care assistants (HCA). Interview with two HCAs inform there is sufficient training available.

The certification audit identified a finding against 1.4.1.4 relating to chemical training. This was prior to the streamlined audit process and has therefore been reviewed against this standard during this surveillance audit. Chemical training was provided in March 2013 (seven staff attended) and the previous finding is now considered to be met.

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

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

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: PA Low
Evidence: There are human resources policies including recruitment, selection, orientation and staff training and development processes. Five staff files reviewed and each has copies of qualifications and employment documentation – care manager, three HCA's and one EN. In each case the performance review was due for review, the majority had been completed for the March 2012-2013 period and therefore the risk is considered to be low.
Finding: Performance appraisals in five of the five staff files reviewed were overdue for review.
Corrective Action: Commence a schedule for updating staff appraisals.
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.

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

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: <p>There is a policy about skills mix. The roster was reviewed and in discussion with the care manger is was noted there are some shifts that are difficult to cover due to long term absence of two regular staff members which is compounded by the management of annual leave requests. On the day of audit it was noted one 'am' HCA shift had not been replaced and this resulted in a shift that was reported by staff and relative interview to be 'busy'. There was no indication that routine clinical care was being compromised however note the finding against 1.3.6. While the rostered numbers meet requirements it is suggested consideration be given to developing a strategy to ensure minimum requirements can be met in the case of unexpected absence.</p>

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; 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
<p>Evidence:</p> <p>D.16.2, 3, 4: The five resident files sampled (rest home, including one respite) identifies the care manager (CM) or registered nurse (RN) completes an initial assessment within 24 hours. Information gathered on admission from needs assessment form, discharge summaries, nursing care discharge summaries, GP health records and letters, allied health notes, resident/family/whanau participation and involvement provide the basis for the initial assessment and initial support care plan. The respite care resident had a short stay assessment and support plan which is used up to 12 weeks and reviewed on each respite care admission. Four of four long-term resident files sampled identified that the long-term resident support plan is developed within three weeks. The resident/family/whanau sign the front page of the long-term support plan to acknowledge their involvement in the development/review of the care plan. There is documented evidence of multidisciplinary reviews (MDT) held three monthly involving the resident/family/whanau, CM or RN and healthcare assistants (HCAs),recreational officer, medical (including medication review) and where applicable allied health input.</p> <p>16.5e: Four of five resident files sampled identified that the GP had seen the resident within two working days. The respite resident GP is aware of the patient's admission for respite care and there is a current letter medical history for the GP in the residents file. It was noted in the four long term resident files sampled that the GP had examined the resident three monthly and carried out a medication review. More frequent medical review is evidenced in files s of residents with more complex conditions or acute changes to health status. The residents retain their own general practitioner (GP). The GPP is unavailable for interview on the day of audit. There is a GP available after hours through the local health centre. The service has access to a nurse practitioner who is employed by the primary health organization (PHO) to provide services to three other rest homes in the area. The nurse practitioner liaises closely with the GP's, reviews medications, undertakes clinical assessments and has limited prescribing rights.</p> <p>There is a verbal handover period between the shifts to ensure staff are kept informed of resident's health status and any significant events. There is a written handover sheet with significant information recorded. Progress notes are written daily and for significant events. The CM states (interviewed) the HCAs are prompt to report any resident changes in health status. Communication diaries are maintained in the nurse's stations.</p> <p>Five rest home resident files sampled:</p>

Tracer methodology; Resident

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.

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

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

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: PA Moderate
Evidence: <p>Residents' support plans are completed by the care manager or registered nurse. When a resident's condition alters, the registered nurses initiate a review and if required, GP or nurse practitioner consultation. Family contact stamps in the resident health status summary notes indicate discussions held with family regarding changes to health, accidents/incidents, infections appointments, and transfers to hospital and GP visits. The HCAs interviewed and CM stated that they have all the equipment referred to in support plans necessary to provide care, including mobility aids, shower chairs, two hoists, pressure area equipment, chair scales, transferring equipment, wheelchairs, gloves, aprons and masks.</p> <p>D18.3 and 4 Dressing supplies are available and the treatment room is well stocked. All staff report that there are adequate continence supplies and dressing supplies. There are short term assessments and support plans and wound progress reports in place for in place for three minor wounds and one pressure area of heel. Complex or chronic wound assessments includes contributing health factors, allergies, nutritional status, length of time wound present, blood supply, any infection/systemic infection, malignancy, smoker, sleep disturbance and any diabetes. There is one chronic wound (leg ulcer). There is evidence of referral to the wound nurse for the chronic ulcer and management notes in the allied health records. A further referral has been sent to the vascular surgeon. Continence products are available and resident files include (where required) a urinary continence assessment, bowel management, wounds and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.</p> <p>A range of assessment tools is completed on admission if applicable including (but not limited to); a) nutritional and fluid assessment b) falls risk (adapted from Morse) c) moving and handling assessment d) Braden pressure area risk assessment e) continence and bowel assessment f) pain assessment g) wound assessment h) behaviour assessment. Risk assessments are completed on admission in five of five resident files sampled and reviewed three monthly. Residents are weighed on admission and monthly. Calibrated chair scales are used. Nutritional and fluids assessment are completed on admission and copies and</p>

notification of dietary changes are sent to the main kitchen off-site. Nutritional assessments are completed for residents with unintentional weight loss. Dietary supplements are implemented. There is an improvement required around food and fluid intake monitoring. Pain assessments are completed on admission for four out of four long term care resident files sampled who identified with pain and reviewed at least three monthly. There is an improvement required around the monitoring of the effectiveness of pain relief.

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

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

Attainment and Risk: PA Moderate
Evidence: There are short term assessments and support plans and wound progress reports in place for in place for three minor wounds and one pressure area of heel. Complex or chronic wound assessments includes contributing health factors, allergies, nutritional status, length of time wound present, blood supply, any infection/systemic infection, malignancy, smoker, sleep disturbance and any diabetes. There is one chronic wound (leg ulcer). There is evidence of referral to the wound nurse for the chronic ulcer and management notes in the allied health records. Residents are weighed on admission and monthly. Calibrated chair scales are used. Nutritional and fluids assessment are completed on admission and copies and notification of dietary changes are sent to the main kitchen off-site. Nutritional assessments are completed for residents with unintentional weight loss. Dietary supplements are implemented. Pain assessments are completed on admission for four out of four long term care resident files sampled who identified with pain and reviewed at least three monthly.
Finding: (i)Five of six wound management plans in place are incomplete. One chronic wound is not linked to the long term care plan. Five out of six wound evaluations/progress notes have not occurred at the required frequency. The pressure area risk and interventions are not documented on the short term care plan. ii) One resident with a nutritional assessment (dated January 2014) score of eight (8) does not have a food and fluid intake chart in place as required. iii) There is no evidence of the monitoring of effectiveness of prn pain relief for resident on controlled drugs. There has not been a review of pain assessment for resident prescribed an increase in pain relief for breakthrough pain.
Corrective Action: (i)Ensure wound management plans are completed. Ensure wound evaluations and progress notes are completed within the required timeframe. Ensure chronic wounds are linked to the long term care plans. Ensure pressure area risk and interventions are documented in the care plan. ii) Ensure food and fluid intake charts are commenced as per nutritional assessment score. iii) Ensure pain assessments are reviewed with change to pain management regime. Ensure the effectiveness of pain relief is monitored
Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

The service employs a full time Recreational team leader who is a qualified diversional therapist (DT) and has been in the role for five years at Reevedon. The DT is supported by another DT (30 hours a week) and a recreational officer (18 hours a week) to implement the activity programme seven days a week across two facilities, Reevedon and another PSC site located close by. The DT team leader is the president of the regional DT group. She is the Eden champion and associate for the PSC facilities. The DTs attend the annual PSC peer support days that maintain skills and knowledge related to their role as well as attending on-site in service as offered. The activity team have current first aid certificates. Volunteers and van drivers participate in the delivery of activities on the programme. Weekly team meetings are held to plan the programme that is also developed in consultation with the residents. Suggestions and feedback on the programme is obtained through resident meetings, surveys and verbal feedback. Interhome activities such as bowls is enjoyed. Entertainment is provided weekly and alternates between the two sites. Residents are encouraged to maintain community links. There are regular outings to community functions and events such as church groups, salvation army and over 60's club and school visits. Weekly inter-denominational church services are held, monthly Anglican services and regular chaplaincy visits.

There is a programme that is resident focused and is planned around meaningful everyday activities such as gardening, baking club, reminiscing, crafts, newspaper reading, blokes bowls, knitting club, games, happy hour, sing-along, movies and is flexible to meet the individual and group preferences. There is a large recreational room with an adjoining kitchen. Mystery café is on Fridays with brought coffees and resident baking. Music therapy and pet therapy is included in the programme. There are other seating areas where individual or quieter activities can take place. One on one activities occur for those residents who choose not to participate in group activity.

Lifestyle forms are completed in consultation with the resident and family on admission of a new resident. The DT completes a resident assessment within three weeks of admission and develops an activity plan which is reviewed at the same time as the care plan.

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:

Three monthly MDT evaluations of the support plan are conducted and involve the GP, RN, HCA's, recreational officer, resident/family/whanau input. The written review form includes general recordings, weight and any issues to be discussed with the GP, medication chart review, and medical examination conducted and GP states the frequency of monthly visits from monthly to three monthly. The resident/family are notified of the review and invited to attend and if unable to attend are notified of the outcome of the reviews as evidenced in four of four long term resident files sampled. The long term support plan is amended with each review if there are changes. Monitoring charts such as weight, blood pressure and pulse, blood sugar level monitoring and behaviour monitoring charts are evidenced in use. Short term support plans are reviewed regularly with problems resolved or added to the long term support plan if an on-going problem.
D16.4a Care plans are evaluated three monthly more frequently when clinically indicated
ARC D16.3c: All initial care plans are evaluated by the RN within three weeks of admission.

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

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

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

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

Attainment and Risk: PA Low
Evidence: <p>There are policies and processes that describe medication management that align with accepted guidelines. The rest home has a keypad medication room. The supplying pharmacy delivers all pharmaceuticals, monthly regular and prn blister packs. The returns are stored safely until collected. Two Care Manager check all medications on delivery against the signing sheet and initials the packs. Any discrepancies are fed back to the supplying pharmacy.</p> <p>All prn medications and expiry dates are checked monthly. The RNs, enrolled nurses (EN) and health care assistants (HCAs) administering medications undergo an annual comprehensive medication competency, self-learning package and audit. Annual medication education was attended October 2013.</p> <p>Controlled drugs are stored in a locked safe and there are weekly stock checks. There is a six monthly pharmacy stocktake last March 2014. Standing orders are not used. There is one self-medicating resident. Self-medication competency has been completed and reviewed three monthly. Medications are stored safely in the resident room and the staff monitor self-medication as per the signing sheet (sighted). All eye drops in use are dated on opening. The medication fridge temperature is monitored weekly. Oxygen supply is checked weekly and the suction equipment checked monthly (checklists sighted).</p> <p>Ten resident medication charts sampled identified all charts had photo identification and allergies/adverse reactions noted. There are no gaps on the medication signing sheets. Two staff sign for the administration of controlled drugs where one is not an RN. Medications are signed by the GP when discontinued. This is an improvement from the previous audit.</p> <p>D16.5.e.i. 2, There is evidence of three monthly GP review of medications on 10 of 10 medication charts sampled. There is a requirement for prn medications to include an indication for use on the medication chart.</p>

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: PA Low
Evidence: Ten resident medication charts sampled identified all charts had photo identification and allergies/adverse reactions noted. There are no gaps on the medication signing sheets. Two staff sign for the administration of controlled drugs where one is not an RN. Medications are signed by the GP when discontinued, there is evidence of three monthly GP review of medications on 10 of 10 medication charts sampled.
Finding: Two out of 10 medication signing sheets do not have indications for use of prn medications.
Corrective Action: Ensure prn medications have the indication for use on the medication chart.
Timeframe (days): 60 (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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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: PA Low

Evidence:

Food services policies and procedures manual is in place. The meals are prepared and cooked off-site at the second PSC facility located close by. Food is delivered to Reevedon in hot boxes and held in the kitchen bain marie until serving. Temperatures are taken and recorded on all hot foods at each meal. There is a kitchen hand daily between 8am-1pm and from 4pm to serve dinner, supper and complete cleaning duties. Breakfast is prepared and served by the HCAs from the kitchenettes within each wing. There is a five weekly summer and winter menu that is reviewed by the company dietitian. The company dietitian is accessible to the service. All residents have a dietary requirements/food and fluid chart completed on admission. A copy of the resident's dietary requirements is sent to the main kitchen. The kitchen hand on site has a list of resident's dietary requirements that include likes/dislikes. Alternative choices are offered. There is daily communication between the kitchen hand and cook regarding the menu and resident requirements. A communication diary is in place for use between the care staff and kitchen hand. This is an improvement since the previous audit. Meal daily requirement forms are filled out daily and sent to the main kitchen. Five of five residents interviewed are happy with the meals provided and confirm likes/dislikes are accommodated and alternative choices offered. An improvement remains around food concerns and outcomes being followed up and communicated to the residents. The kitchen is accessible after hours and there are snacks available for residents.

The kitchen has cooking and heating facilities. There is a walk in chiller, fridges and freezer. Temperatures are monitored daily. The chiller is out of order on the day of audit and the contractor notified. Chilled foods are stored in alternative facility fridges. Foods are date labelled. All food items in the pantry are sealed and dated and off the floor. All facility fridges are temperature monitored (records sighted).

The kitchen hand is observed to be wearing appropriate personal protective clothing. Daily and weekly cleaning duties are completed and signed off (sighted).

D 19.2. The kitchen hands have completed food safety and hygiene training and chemical safety training.

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:

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Finding:

Corrective Action:

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

Criterion 1.3.13.2 (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: PA Low
Evidence: A copy of the resident's requirements is sent to the main kitchen. The kitchen hand on site has a list of resident's dietary requirements that include likes/dislikes. Alternative choices are offered. There is daily communication between the kitchen hand and cook regarding the menu and resident requirements. Meal daily requirement forms are filled out daily and sent to the main kitchen. Five of five residents interviewed are happy with the meals provided and confirm likes/dislikes are accommodated and alternative choices offered. The kitchen is accessible after hours and there are snacks available for residents. Food services are discussed at the resident meetings.
Finding: Resident meeting minutes September and November 2013 and February 2014 has some discussion around food services. There is no evidence of concerns raised followed up and outcomes communicated to the residents. The previous shortfall remains.
Corrective Action: Ensure concerns around food services are followed up.
Timeframe (days): 90 (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 facility has a current building warrant of fitness that expires 28 February 2015 and a current fire evacuation approval. There is a planned maintenance schedule in place. Hot water temperature monitoring is stable at 44-45 degrees Celsius. The interior and exterior of the facility is well maintained. There is a designated smoking area. HCAs and the care manager interviewed state there is adequate equipment to safely deliver care as instructed in the resident care plans including; mobility aids, chair scales, shower chairs, electric beds (as required), gloves, aprons and masks. There is a bed replacement programme in place for four electric beds per year.

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.)*

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.

Attainment and Risk: FA

Evidence:

Finding:

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: Maintenance has been carried out on the three toilet and bathrooms identified for improvement at the previous audit. The previous shortfall has been addressed.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence:
There are policies and procedures in place is enablers are required. On the day of audit there are no restraints or enablers in use.

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

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: <p>There is an infection control policy that included surveillance activities. The policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control policy is reportedly being reviewed at the time of audit. There is an infection control (IC) coordinator for the facility. Infections are reported using an infection data sheet and collated monthly onto a summary sheet/register. Reevedon submits data as part of the QPS benchmarking programme and information is also used to compare against other PSS facilities. Infections are discussed as part of the senior staff meetings (minutes sighted) and data is available in the Reevedon staff room. There is one ESBL +ve resident at the time of audit and appropriate infection control strategies are seen to be in place. Internal infection control audits are completed and results reported through to senior staff meetings and infection rates evidence in the staff room. The surveillance programme is appropriate to the size and complexity of the facility.</p>

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

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