Sunrise International Funds Limited

Current Status: 17 April 2014

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

General overview

Howick Manor Rest Home is certified to provide dementia level care with a total of 21 residents occupying 24 available beds on the day of the audit. The duty manager is on site with staff that are trained in dementia care and there is a full time registered nurse. Family members spoke highly of the service.

Seven of nine shortfalls identified at the previous audit have been addressed. These are around: advance directives, policies and procedures, the risk register, training records, review of the brochure, the restraint policy and review of the infection control programme.

Two improvements required at the previous audit remain. These are around transcribing of medication information and shelving in the pantry.

This audit has identified further improvements are required around the call bell system, documentation of strategies to manage challenging behaviour, the activity programme and cleaning of the kitchen.

Audit Summary as at 17 April 2014

Standards have been assessed and summarised below:

Key

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

Indicator	Description	Definition
	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 17 April 2014

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

Organisational Management as at 17 April 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Continuum of Service Delivery as at 17 April 2014

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

Safe and Appropriate Environment as at 17 April 2014

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

Restraint Minimisation and Safe Practice as at 17 April 2014

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

Infection Prevention and Control as at 17 April 2014

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

HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

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

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

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

Audit Report

Legal entity name:	Sunrise International Funds Limited
Certificate name:	Sunrise International Funds Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Surveillance Audit			
Premises audited:	Howick Manor			
Services audited:	Rest home care (excluding dementia care)			
Dates of audit:	**Start date:**	17 April 2014	**End date:**	17 April 2014

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit:	21

Audit Team

Lead Auditor	XXXXX	**Hours on site**	8	**Hours off site**	4
Other Auditors		**Total hours on site**		**Total hours off site**	
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	8	Total audit hours off site	6	Total audit hours	14

Number of residents interviewed		Number of staff interviewed		Number of managers interviewed	3
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	4
Number of medication records reviewed	10	Total number of staff (headcount)		Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of 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 Thursday, 8 May 2014

Executive Summary of Audit

General Overview
Howick Manor Rest Home is certified to provide dementia level care with a total of 21 residents occupying 24 available beds on the day of the audit. The duty manager is on site with staff that are trained in dementia care and there is a full time registered nurse. Family members spoke highly of the service. Seven of nine shortfalls identified at the previous audit have been addressed. These are around: advance directives, policies and procedures, the risk register, training records, review of the brochure, the restraint policy and review of the infection control programme. Two improvements required at the previous audit remain. These are around transcribing of medication information and shelving in the pantry. This audit has identified further improvements are required around the call bell system, documentation of strategies to manage challenging behaviour, the activity programme and cleaning of the kitchen.

Outcome 1.1: Consumer Rights
Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs and family state that they are fully informed at all times. An interpreter's policy is in place and external assistance is available if necessary. The complaints procedure is provided to residents and relatives as part of the admission process and the complaints register is up to date with evidence of timely resolution of complaints. The improvement required at the previous audit around advance directives has been addressed.

Outcome 1.2: Organisational Management
Howick Manor has a quality and risk management system implemented. Key aspects of the quality improvement and risk management programme include monitoring of incidents and accidents, health and safety, implementation of an internal audit schedule and surveillance of infections. There is an annual family satisfaction survey. The service has policies and procedures that are reviewed by an external consultant. The service has human resources procedures for staff recruitment and employment and there is an implemented orientation programme and annual training schedule that is implemented. Staffing levels safely meet the needs of the residents and all caregiving staff have either completed the dementia training or if newly appointed, are enrolled in the programme. Improvements required from the previous audit have been addressed as follows: to policies and procedures, to documentation of the risk register and recording of training records. Improvements are required to the call bell system.

Outcome 1.3: Continuum of Service Delivery
The service has a current information brochure; this is an improvement since the previous audit. The service has a documented assessment process and there is an information pack available for residents/families at entry. Care plans are individualised and evaluated six monthly or as changes occur. The service facilitates access to other medical and non-medical services. Improvements are required to documentation of strategies to manage challenging behaviour. The activities coordinator and all staff provide a varied activity programme with residents actively engaged at all times. Improvements are required to the

activities programme around documentation of a 24-hour activity plan, ensuring that there are six monthly reviews for the activities programme for each resident and ensuring oversight of the activities programme by a qualified staff member.
The medication management system includes a documented policy and procedure with medication locked away and staff administering medication in a safe and timely manner. An improvement required at the previous audit remains to transcribing of medication information.
Meals are prepared on site by the cook and individual and special dietary needs are catered for. Residents and family interviewed responded favourably to the food that is provided.

Outcome 1.4: Safe and Appropriate Environment

A current building warrant of fitness is posted in a visible location at the entrance to the facility; there have been no building modifications since the last audit.
There is a planned maintenance schedule implemented. The lounge area is designed so that space and seating arrangements provide for individual and group activities with are two other lounge areas available. There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required.
There are safe outside areas that are easy to access for residents and family members, these include outdoor shade, tables and chairs. The site is secure with a large gate, fence and pin code to ensure that there is a secure environment for residents.
The District Health Board specifically requested review of laundry and cleaning following a complaint in 2013 (unsubstantiated). All resident areas, bathrooms, dining areas and lounge areas are clean on the day of the audit. The night or afternoon staff are required to clean the kitchen on a weekly basis. The kitchen was not cleaned adequately on the day of the audit, this requires improvement. The cabinetry in the kitchen has been changed to ensure that materials are able to be washed. The only exception to this is the shelving in the pantry which has some areas of exposed particle board so improvement continues to be required.

Outcome 2: Restraint Minimisation and Safe Practice

Policies and procedures for restraint minimisation and safe practice are fully implemented. All residents undergo a detailed risk assessment and care plans are implemented to ensure that restraint is not used. There is no use of enablers or restraint at Howick Manor apart from the locked gate to the outside community noting that this is appropriate given the certification as a secure unit. The restraint policy refers to providing a stage three secure environment. The improvement required at the previous audit has been addressed.

Outcome 3: Infection Prevention and Control

The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control co-ordinator (registered nurse) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the service. There are audits of the environment. Infection control is linked into the quality improvement programme.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	14	0	3	2	0	0
Criteria	0	38	0	3	2	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	31
Criteria	0	0	0	0	0	0	0	58

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 Moderate			
HDS(C)S.2008	Criterion 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;	PA Moderate	Call bells cannot be heard in the laundry and far hallways and bedrooms and lights on the monitors do not all work. Residents can turn the monitors on and off. The system was off when the auditor tried to call initially and the duty manager checked and turned it back on at the time.	Ensure that the call bells can be heard by staff at any time in any part of the building.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		(b) A process that addresses/treats the risks associated with service provision is developed and implemented.				
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 Low			
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 Low	Staff describe a number of strategies that support staff to de-escalate issues. However these, while individualised to the resident, are not documented in the care plan.	Ensure that strategies to manage challenging behaviour are well documented in care plans.	90
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	PA Low			
HDS(C)S.2008	Criterion 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.	PA Low	i) A 24-hour activity plan for individual residents is not documented. ii) Six monthly reviews are not completed in a timely manner for four of five residents reviewed. iii) There is no oversight of the activities programme by a diversional therapist or occupational therapist or other qualified person.	i) Document a 24-hour activity plan for individual residents. ii) Ensure that there are six monthly reviews for the activities programme for each resident. iii) Ensure that there is oversight of the activities programme by a diversional therapist, occupational therapist or other relevant person.	180
HDS(C)S.2008	Standard 1.3.12:	Consumers receive medicines	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Medicine Management	in a safe and timely manner that complies with current legislative requirements and safe 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	There is transcribing in the PRN charts and on the 'special instructions' relating to PRN medication.	Cease the practice of transcribing.	60
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	i) The kitchen was not cleaned adequately on the day of the audit. ii) Some shelves in the pantry have exposed particle board and cannot be cleaned effectively.	i) Ensure that the kitchen is cleaned adequately. ii) Ensure that shelving in the pantry is able to be cleaned effectively	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: The policy on open disclosure describes requirements to share information, including adverse events, with residents and their family. Residents and their family are provided with a welcome pack at entry that includes the admission agreement, information about the service as a secure dementia unit and information about complaints and open disclosure. Contact with the family/nominated representative is recorded on the accident and incident form (sighted on 10 of 10 completed forms). The policy on interpretation and translation services includes contact information for translation services. There are no residents currently requiring an interpreter although there are some residents who are mandarin and English speaking and two staff and two directors who are also able to converse in mandarin. One resident identifies as XXXX and is also able to converse in English – observed on the day of the audit. 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. D16.1b.ii 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 Five of five relatives report they are kept informed when their family member's health status changes. D11.3 The information pack is available in large print and advised that this can be read to residents. The staff, particularly the registered nurse records all communication with family members on the communication form in each resident file and this comprehensively documents discussions. All five family members state that the ability to be kept updated and communication with the service is a highlight for them.

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

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

Attainment and Risk: FA
Evidence:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk:	FA
Evidence:	

There is a process for completion of advance directives documented and implemented that is appropriate for the needs of the dementia client group. In the past, the family members have signed the advance directive form. The doctor now documents the form with 'not deemed competent to give advance directives' documented and the general practitioner also documents that the resident is not for resuscitation. In the sample of five files reviewed, five of five have been signed by the general practitioner as per the new direction. Two files are for residents who have been in the service prior to the previous audit and have a resuscitation status signed off by the general practitioner as not competent to sign however the family have also signed to state that they have had input. The duty manager and registered nurse are clear around family not being able to sign advance directives but are trying to contact the family to include them in the discussion prior to changing the form. Two other files for residents who have entered the service in the last year were reviewed just to look at the advance directives and both have been signed on the new form by the general practitioner deeming not for competence only.

The improvement required at the previous audit has been addressed.

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

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

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

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

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

Attainment and Risk: FA
Evidence: Family are informed of their right to complain and the service facilitates their ability to do so. There is a clearly defined complaints procedure as part of the policy which complies with the code of rights. The policy states that all complainants will be notified within five working days on receipt of complaint, and other timeframes are in line with the Code. Five of five family members note that they were aware of the complaints process but said that they had not had the need to complain. Family interviewed confirm that they are delighted with the service provided. There has been one complaint lodged with the District Health Board since the last audit as confirmed by the duty manager. A response from the District Health Board confirmed that the complaint was unsubstantiated. The audit checked cleaning of the facility (refer 1.4.2) and confirmed that there are plenty of gloves and other personal protective equipment available including hats and aprons. The complaints register is available to document any complaints in if forwarded. There have been no other complaints in 2013 or 2014 to date. D13.3h. A complaints procedure is provided to resident as able and to families within the information pack at entry. E4.1biii.There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on minimising restraint, behaviour management and encouragement for families to complain if there are any issues.

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
Evidence: Howick Manor Rest Home is a dementia unit of up to 24 residents with occupancy of 21. There is a duty manager who is involved on a daily basis with the service. The duty manager is part of a management team (this facility, Palm Home and Hospital and Kolmar Lodge Rest Home). The two directors are hands on and visit each site daily and can come at any time as confirmed by the two duty managers interviewed. All duty managers can relieve for each other. The duty manager lives upstairs and is on call at all times. The duty manager has over 20 years' experience in aged care and has been in the service for 10 and a half years. The three duty managers and one director have completed the aged care education (ACE) dementia training. There is a registered nurse with a current annual practicing certificate who has seven years' experience in aged care and has been a registered nurse for 10 years. The service has a mission and values and business plan 2013. The mission statement is 'an act of merciful love is only really such when we are deeply convinced at the moment we perform in it, that we are at the same time receiving mercy from the people accepting it from us' with the by-line - 'a special home providing the best of care with respect'. This is reviewed by the directors as necessary. ARC E2.1The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. Discussion with the two duty managers and all other staff including the registered nurse, activities coordinator and three caregivers indicates the service concentrates on engaging residents in household jobs with support for activities of daily living. Five of five family interviewed confirm that the philosophy is lived by the service through the passion and commitment of the manager and staff. ARC,D17.3di The two duty managers and both directors have maintained at least eight hours annually of professional development activities related to managing an aged care facility for residents with dementia.

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: The business plan 2013-15 describes strategies, strategy details and business inputs and issues and cost. Progress against goals is completed by the manager as part of the management and staff meeting. There are staff meetings in the service to review progress against the quality and risk management programme. The meetings include adverse events reported for the period, complaints, infection control, internal and external audits, family feedback, health and safety and any issues including review of care. The audit schedule for 2013 is followed each month and includes cleaning, medicine administration, personal care and grooming, documentation, continence, hand washing, activities, privacy, laundry, food services. Corrective actions are documented on the audit forms. There are annual family satisfaction surveys – last collated in 2013 with very positive feedback. The service is just about to send out the next family satisfaction survey. Staff are invited to provide suggestions/feedback through the bi-monthly staff meetings and staff state that they are kept well informed about quality related activity and appreciate the range of opportunities available to contribute to discussion (confirmed during interview with three of three caregivers). Health and safety policies are implemented and monitored by through staff, management and the activities meetings. Risk management, hazard control and emergency policies/procedures are in place. Hazard identification and control is up to date with a hazard register in place. The general practitioner interviewed confirmed satisfaction with the service and said that the service had keep improving over the last four years with evidence of improvements made. D5.4 The service has purchased policies from an external contractor and these are updated by the consultant. Document control and control of documents policies guide policy/document control. A checklist documents the date of review for all policy manuals. The numbers of the advocacy service displayed in the foyer have been updated and the policy with numbers in it has also been updated. The improvements required at the previous audit have been addressed. D19.3 There is an organisational risk management plan documented and reviewed at the two monthly management meetings. The directors and duty managers attend

from all three facilities owned by the directors attend along the registered nurse and other staff as required. The generic risk management plan from the purchased policies and the service risk management plan have been joined. The improvement required at the previous audit has been addressed.
D19.2g Falls prevention strategies are in place.
The service focuses on quality improvement that enhances the service for residents with dementia.
A risk around the call bell system has been identified. The call bell system includes a call bell in each room that is connected to one of three monitors. The monitors are located in the hallway outside the nurse's station and the sound can be turned off and on. The residents are described as often turning the monitors on and off and some of the lights do not light up to indicate which bell in which room has been rung. The call bells cannot be heard in all parts of the facility.
An improvement is required to the call bell system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

Attainment and Risk: PA Moderate
Evidence: There are call bells in all rooms in the facility that connect to panels by the nurse's station The call bells can be heard if staff are by the nurse's station and surrounding areas. The call bell system includes a call bell in each room that is connected to one of three monitors. The monitors are located in the hallway outside the nurse's station and the sound can be turned off and on. The duty manager states that staff do not ring bells and cares are predominantly completed in pairs. Staff were observed calling out to each other on the day of the audit however if a staff member called out from the opposite end of the building to where the other staff member was, then they could not be heard. Staff at night carry a phone in their pocket and can call the duty manager who lives upstairs at any time.
Finding: Call bells cannot be heard in the laundry and far hallways and bedrooms and lights on the monitors do not all work. Residents can turn the monitors on and off. The system was off when the auditor tried to call initially and the duty manager checked and turned it back on at the time.
Corrective Action: Ensure that the call bells can be heard by staff at any time in any part of the building.
Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: FA
Evidence: D19.3b: Policies on incident reporting and accident reporting and investigation procedures describe the adverse event reporting process. Accident and incident reports are investigated by the registered nurse and signed off as being reviewed with any actions documented. Accident and incident reports document the event, the date, those involved, the investigation, suggested and completed actions and whether the family member has been informed (sighted in 32 of 32 accident/incident reports). Accident and incident data is discussed at staff meetings. The staff meet bi-monthly and there is a monthly director meeting to review trends and discuss issues. D19.3c: The duty manager is aware of notification responsibilities and is able to describe these. The duty manager states that there has been no need to inform any authority of any major events since the last audit.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: There are policies on orientation, recruitment and credentialing. Job descriptions are in place and describe the position, functional relationships, primary objectives, key tasks and expected results for each role. The registered nurse, general practitioner, podiatrist, dietician, pharmacist have a current practising certificate - sighted. Recruitment processes are described by the duty manager as including an application process, interview and referee checks. All new employees complete a documented orientation process which includes working with a support person of the same role buddying the new staff member. The orientation programme covers the essential components of the service provided including how to work with residents with dementia. Three of three caregiver's state that they have had an appropriate recruitment, interview and employment process with an orientation completed that comprehensively covered key areas of the service. They also state that they have training monthly and all training is relevant to their roles. The training plan is implemented with the following topics completed since January 2013; infection control, safe food handling, challenging behaviour, restraint, pain management, falls prevention, safe handling of chemicals, medication administration, continence, complaint management, sexuality and intimacy, informed consent, cultural safety. Topics related to clinical topics are facilitated by the registered nurse. External facilitators are used when possible e.g. pharmacy, Aged Concern. Training records for five of five staff members indicate that they attend all programmes (compulsory training with staff rostered to attend). E4.5f: Nine of 11 caregivers are trained in dementia care, one is doing the training and one has been with the service for two weeks and is already enrolled. Training records are retained on individual staff files. All five staff files reviewed include a signed contract. E4.5d The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

The staff training records sighted are complete. The improvement required at the previous audit has been addressed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: The service has a service management policy and rosters sighted indicate that staff are allocated appropriately. There are a total of 22 staff including the duty manager, registered nurse (30 plus hours a week), activities coordinator (two and a half hours seven days a week), two cooks, director/maintenance, one administrator, two cleaners, 11 caregivers. Staffing for up to up to 24 residents with 21 residents on the day of audit is implemented as per the following roster: Duty manager: Monday to Friday and on call 24 hours a day, registered nurse (five days a week for at least 30 hours a week). AM: four caregivers (two from 7am-2pm, one from 7am-9am, one from 8.30am-10.30. PM: two caregivers from 2pm-10pm and one from 2pm to 730pm. Night: One staff from 11pm-7am with the duty manager living upstairs and on call at all times. The caregiver who has worked on night shift interviewed states that the duty manager comes directly downstairs when called. The two directors are hands on and visit daily and when called. Five family interviewed state that there are sufficient staff on duty.

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

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

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

Outcome 1.3: Continuum of Service Delivery

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

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Attainment and Risk: FA
Evidence: The home has a brochure, which is available to prospective residents and their families. The brochure has been updated to state that the duty manager lives on site (previously 1.3.1.1). The improvement required at the previous audit has been addressed.

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

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

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

Attainment and Risk: FA
Evidence: D16.2, 3, 4; Assessment, planning, evaluation, review and exit are undertaken by the registered nurse with input from the duty manager and caregivers. Service delivery is undertaken by care giving staff, the activities coordinator, the duty manager and the registered nurse. The five files reviewed identify that in all files the initial assessment and plan has been dated and signed. There is evidence of a reassessment with the specialised assessment tools including dietary needs, pressure area and falls risk assessments completed six monthly. E3.1 Five resident files reviewed of residents in the dementia service include a needs assessment as requiring rest home dementia care. Five of five files include an initial assessment completed within 24 hours, an initial care plan completed within 48 hours and general practitioner review within 48 hours of admission. All have a long term first developed within three weeks of admission and all have a care plan reviewed six monthly or as changes occur. Residents and the family members interviewed indicate that they are involved in the assessment and planning process. D16.5e; Residents have access to a general practitioner with residents having a three monthly review or more frequent review as required. Frequency of review by the general practitioner is documented in the doctor's notes. The registered nurse communicates well with the general practitioner as confirmed by the general practitioner interviewed. Five family members interviewed report they are aware of all matters pertaining to the resident. The care plan is kept in the resident's file and made available to specialists and allied health professional. Three care givers and the registered nurse can describe hand over processes and the handover observed detailed any on-going needs of each resident. E4.2 Five files reviewed include an individual assessment that included identifying diversional, motivation and recreational requirements (link 1.3.7). E4,2a Challenging behaviours assessments and management plans are completed in the files reviewed noting that strategies are briefly described (link 1.3.6). Tracer: 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): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: PA Low
Evidence: The care being provided is consistent with the needs of residents as evidenced by discussions with two caregivers, five relatives, the registered nurse and duty manager. The general practitioner interviewed on the day of audit is complimentary of the care residents receive and states that staff inform the general practitioner in good time of any concerns they may have regarding residents health status. Files reviewed include: a) one rersident with a change to requiring palliative care and a wound, b) resident with a chronic ulcer, c) new admission, d) resident with very challenging behaviour including verbal and physical aggression, e) resident with lymphedema. Interventions and strategies are well documented related to management of UTI's, interventions to prevent falls and around wound management. Interventions include frequent fluids, monitoring of behaviour as an indication of UTI's, use of equipment such as pressure cushions and lifting belts, monitoring of incidents and accidents, documentation of any infections on the infection register with review by the registered nurse, hip protectors in use, elevation of resident legs as required, monitoring of pain with PRN pain medication given as prescribed through observation of resident's behaviour and expressions. Weight of all residents is reviewed monthly with this increased to fortnightly for one resident with weight loss. The resident also has supplements, monitoring of intake, a high protein diet, review by the dietician with evidence of an increase in weight. Staff describe a number of strategies that support staff to de-escalate issues however these, while individualised to the resident, are not documented in the care plan. This is an area requiring improvement. Staff including the activities coordinator and caregivers were seen to be actively engaging residents in activities during the day of the audit. There is evidence of referral to specialists when required e.g. to the district nurse, wound nurse specialist, gerontology nurse specialist and gerontologist, general practitioner. Family interviewed (five of five) state that they are asked frequently about what interventions they would like to see happen and feel that they are well communicated with and are able to have a lot of input into care.

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 Low
Evidence: The service has a number of residents with challenging behaviour. The long term care plan includes documentation of some strategies to manage behaviours.
Finding: Staff describe a number of strategies that support staff to de-escalate issues. However these, while individualised to the resident, are not documented in the care plan.
Corrective Action: Ensure that strategies to manage challenging behaviour are well documented in care plans.
Timeframe (days): 90 *(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: PA Low
Evidence: D16.5d Resident files reviewed identified that the individual activity assessment is completed on entry to the service. This includes a social history. Residents are quick to engage or not which indicates likes and dislikes. The activity assessment and documentation is developed with the relative whenever possible and reviewed at least six monthly. Five of five files reviewed include an activity plan with one of five reviews completed in a timely manner. A 24-hour activity plan for individual residents is not documented. These are areas requiring improvement. Caregivers were observed at various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with dementia and one to one care needs with residents actively engaged in activities including crafts, exercise, walking etc. The activities coordinator is passionate about making a difference in resident lives through activity and all staff including the duty manager are committed to providing activities to keep residents busy, engaged and active. The environment has been designed to create activities for people with a large outdoor area that includes gardens, lots of areas to walk in and paths that lead back to the inside. An attendance register is kept for each individual resident detailing their engagement in activities. Residents were observed to be really enjoying the programme and activities. There is no oversight of the activities programme by a diversional therapist or occupational therapist or other qualified person. This is a further area requiring improvement.

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: PA Low
Evidence: The activities coordinator writes the activities for the week on the white board in the foyer and there is a framed annual plan of activities. There is an assessment completed when the resident enters the service and an activity plan evaluation. There is an attendance register for each resident and the activities coordinator is expected to review documentation and involvement six monthly. One of the five files reviewed had a six monthly review of the plan.
Finding: i)A 24-hour activity plan for individual residents is not documented. ii) Six monthly reviews are not completed in a timely manner for four of five residents reviewed. iii) There is no oversight of the activities programme by a diversional therapist or occupational therapist or other qualified person.
Corrective Action: i) Document a 24-hour activity plan for individual residents. ii) Ensure that there are six monthly reviews for the activities programme for each resident. iii) Ensure that there is oversight of the activities programme by a diversional therapist, occupational therapist or other relevant person.
Timeframe (days): 180 *(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: D16.4a Evaluation timeframes are specified in policies and procedures. Evaluations are conducted by the registered nurse six monthly or when a resident's condition alters. The registered nurse completes reviews of the care plans with input described by the registered nurse and caregivers. Care staff monitor resident's progress on a shift-by-shift basis and report any concerns to the duty manager and registered nurse with progress notes recording progress. Five of five family members confirm input into reviews.

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: Policies and procedures on medicine management include prescribing and dispensing, self-administration, storage and disposal, staff administration, controlled drugs, staff training and competencies and monitoring medication errors. The medication is kept in a locked cupboard in the dining room and the controlled drugs are kept in a double locked cupboard in another part of the service. One resident using a controlled drug had this administered correctly on the day of the audit. There is a weekly stocktake completed and documentation indicating that balances are correctly recorded. Three balances of controlled medication were checked on the day of the audit and are correctly documented. A medication round observed indicates that staff take the trolley with medications with them at all times. It is not left unattended. Ten of 10 medication files checked indicate that all are documented correctly in the administration records. All include photo identification and all have allergies and sensitivities recorded in the medication file and the resident file. Medicines for residents are received from the contracted pharmacy and checked on entry to the service by the registered nurse. Signatures of staff can be identified. All staff responsible for medication management have completed annual medication competencies and records are maintained. Ten of 10 medication records reviewed have been reviewed three monthly by the general practitioner and this is verified by the general practitioner interviewed. There are no residents self-administering medication and this is not appropriate in the dementia unit. The caregiver was observed to sign for medications at the time of administering the drugs. There are no eye drops currently in use however the registered nurse described a process of dating them when opened. There is evidence of transcribing in files reviewed. The improvement required at the previous audit remains.

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: The registered nurse interviewed is clear around what transcribing is. A discussion with the duty manager from the previous site audited confirmed the confusion and the registered nurse is clear now that the files are to be returned to their previous state with no transcribing.
Finding: There is transcribing in the PRN charts and on the ‘special instructions’ relating to PRN medication.
Corrective Action: Cease the practice of transcribing.

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

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

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

Attainment and Risk: 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 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

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

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

Attainment and Risk: FA
Evidence: Fluids are provided with each meal, jugs of water are available and morning tea, afternoon tea and supper is provided. Any dietary requirements are identified in the dietary profile which is undertaken on admission by the registered nurse and updated as required. A copy is kept in the individual resident file and the cook has a copy or list of requirements. The cook interviewed explained that the kitchen staff can cater for all dietary requirements and there are instructions related to what should be provided. There are no special diets currently however residents requiring dietary supplements have these provided (sighted during the audit). The kitchen has cooking appliances for the numbers to be catered for. All food supplies are delivered on a regular basis to meet the menu requirements. Food is stored safely, labelled with contents and expiry dates are monitored. D19.2: All kitchen staff have attended food safety training and completed the necessary requirements. The duty manager has experience as a chef and oversees the kitchen processes. Five of five family members interviewed confirm that the food meets the approval of their family member from their observation and residents appeared to enjoy the meal at lunchtime. When residents are losing significant weight, the cook states that the kitchen is notified. Residents are weighed monthly whenever possible noting that at times, there are some challenging behaviours. There is sufficient stored food to provide meals to residents for three days at least in the event of an emergency. E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours. There is temperature recordings of the freezers and chiller and food temperatures recorded three times a week with documentation indicating that all food temperatures

are in the correct range.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action: Check the temperature of hot food (particularly meat) when cooked.
Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: A current building warrant of fitness is posted in a visible location at the entrance to the facility and is current (expiry date 4 March 2015). There have been no building modifications since the last audit. There is a planned maintenance schedule implemented. D15.3d; E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounge on the day of the audit. There are two other lounge areas available. Interviews with three of three caregivers confirms there is adequate equipment including lifting belts. E3.3e; There are quiet areas throughout the facility for resident and visitors to meet and there are areas that provide privacy when required. The facility is spacious. There are safe outside areas that are easy to access for residents and family members. These include outdoor shade, tables and chairs. The site is secure with a large gate, fence and pin code to ensure that there is a secure environment for residents. There is sufficient space to allow residents to move around the facility freely. All bedrooms have sufficient space for equipment and for staff to work. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip

linoleum in showers and toilet areas and throughout the facility.
The cabinetry in the kitchen has been changed to ensure that materials are able to be washed. The only exception to this is the shelving in the pantry which has some areas of exposed particle board. The previous improvement required remains (previously 1.4.2.3). An improvement is also required to cleaning of the kitchen.
The District Health Board specifically requested review of laundry and cleaning following a complaint in 2013 (unsubstantiated).
All resident areas, bathrooms, dining areas and lounge areas are clean with a cleaner employed seven days a week from 9am-1.30pm with extended hours available when required. The cleaner was observed on the day of the audit to use notices to identify wet floor and to adequately clean toilet, bathrooms, bedrooms and communal areas.
The night or afternoon staff are required to clean the kitchen on a weekly basis. The kitchen was not cleaned adequately on the day of the audit.

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: PA Moderate
Evidence: The District Health Board specifically requested review of laundry and cleaning following a complaint in 2013 (unsubstantiated). All resident areas, bathrooms, dining areas and lounge areas are clean with a cleaner employed seven days a week from 9am-1.30pm with extended hours available when required. The cleaner was observed on the day of the audit to use notices to identify wet floor and to adequately clean toilet, bathrooms, bedrooms and communal areas. The night or afternoon staff are required to clean the kitchen on a weekly basis. There are safe locked storage areas for chemicals.

Finding: i)The kitchen was not cleaned adequately on the day of the audit. ii) Some shelves in the pantry have exposed particle board and cannot be cleaned effectively.
Corrective Action: i)Ensure that the kitchen is cleaned adequately. ii) Ensure that shelving in the pantry is able to be cleaned effectively
Timeframe (days): 90 *(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.

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: Policies and procedures for restraint minimisation and safe practice are fully implemented. All residents undergo a detailed risk assessment and care plans are implemented to ensure that restraint is not used. The policy specifies that enablers are to be used on a voluntary basis but no enablers are in use currently. Staff receive on-going education in the policy for restraint minimisation and the management of challenging behaviour with the last training provided in April 2014 and December 2013. There is no use of enablers or restraint at Howick Manor apart from the locked gate to the outside community noting that this is appropriate given the certification as a secure unit. The restraint policy refers to providing a stage three secure environment. The improvement required at the previous audit has been addressed.

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

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

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

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

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: A review of the infection control programme is completed annually – last completed in November 2013. The improvement required at the previous audit has been addressed.

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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 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: Surveillance frequency and type is set out in policy and determined by the organisation`s infections control policies and procedures that are reflective of the service offered at this rest home. Surveillance data is undertaken as required in the Health and Disability Services Standards Infection and Prevention Control Standards 2008. Infection control data is collected on site and documents resolution of the infection. There is monthly documentation of infections and a graph that enables trends to be analysed. The registered nurse interviewed has a good understanding of the surveillance system and significance of collecting the data.

The service is active in monitoring UTI's and ensuring that the frequency of these decreases. The general practitioner states that the registered nurse is good at monitoring infection rates and of informing the general practitioner if there are any trends or issues.

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

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

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

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

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

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