

Henrikwest Management Limited - The Beachfront

Current Status: 3 June 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

The Beachfront Rest Home offers rest home care to 41 residents. On the day of audit 36 beds are occupied.

There were five areas requiring improvement identified at the previous audit; these areas are now addressed, with the implemented improvements embedded into practice. There are no new areas requiring improvement identified at this audit.

Audit Summary as at 3 June 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 3 June 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 3 June 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 3 June 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.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 3 June 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 3 June 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 3 June 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:	Henrikwest Management Limited		
Certificate name:	Henrikwest Management Limited - The Beachfront		
Designated Auditing Agency:	The DAA Group Limited		
Types of audit:	Surveillance Audit		
Premises audited:	The Beachfront Rest Home		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	Start date: 3 June 2014	End date: 3 June 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:	36
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Audit Team

Lead Auditor	XXXXX	Hours on site	6	Hours off site	4
Other Auditors	XXXXX	Total hours on site	6	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	12	Total audit hours off site	10	Total audit hours	22
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Number of residents interviewed	8	Number of staff interviewed	6	Number of managers interviewed	4
Number of residents' records reviewed	4	Number of staff records reviewed	5	Total number of managers (headcount)	6
Number of medication records reviewed	8	Total number of staff (headcount)	25	Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

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

I confirm that:

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

Dated Wednesday, 9 July 2014

Executive Summary of Audit

General Overview

The Beachfront Rest Home offers rest home care to 41 residents. On the day of audit 36 beds are occupied, with one of these being a short term contract for the provision of palliative care.

There were five areas requiring improvement identified at the previous audit; these areas are now addressed, with the implemented improvements embedded into practice. There are no new areas requiring improvement identified at this audit.

Outcome 1.1: Consumer Rights

Residents and family/whanau report they receive full and frank information and open disclosure from the staff.

The service has an easily accessed, responsive and fair complaints process. There is an up-to-date complaint register maintained that includes all complaints, dates, and actions taken. Written and verbal complaints are recorded in the log. Since the previous audit there have been two external complaints investigated through the DHB, with one of these now closed and the remaining complaint yet to be finalised.

Outcome 1.2: Organisational Management

Organisational structures and processes are implemented by the service to ensure service delivery is planned, co-ordinated, and appropriate to the needs of the consumers. Service performance is aligned with, and regularly monitored against, organisational goals as identified in the business plan. The management team consists of suitably qualified and experienced staff who have delegated authority, accountability and responsibility for the provision of service.

Quality and risk management systems are documented and implemented by the service. They reflect continuous quality improvement principles. Service deficits are documented as corrective actions and followed-up appropriately. Key components of service delivery are explicitly linked to the quality risk management plans and are monitored to measure achievement. Adverse event reporting is undertaken using incident and accident forms. The previous audit identified that incident and accident forms are not always completed by staff to indicate that family/whanau have been informed; this issue is now addressed.

The service implements safe staffing levels and skill mixes that are clearly set out in policy. Human resources management processes in place meet legislative requirements. Staff are fully supported by the organisation to maintain and improve their knowledge and skills through on-going education which is appropriate to their role.

Outcome 1.3: Continuum of Service Delivery

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring rest home level care. Staff are trained and qualified to perform their roles and deliver all aspects of service provision. A senior registered nurse oversees the care and management of all residents along with a team of caregivers. All residents are assessed on admission and assessment details are retained in the individual resident`s records.

The residents` care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required, with resident and family input being sought. The general practitioner interviewed reports that all residents are seen on admission and explained that full medical cover is provided for all residents 24 hours a day. Documentation is reviewed within timeframes as required for this service. The previous corrective actions have been completed.

The activities available are appropriate for residents requiring rest home level care. The activities coordinator and qualified diversional therapist have a shared role.

Medication management systems comply with current legislation and all clinical staff involved in medicine management undergo competency assessment annually. The senior registered nurse (RN) and caregivers are responsible for all areas of medication management and work alongside a contracted pharmacy. The previous corrective actions have been completed.

The food service is prepared on site and overseen by two cooks over seven days. The menu plans have been reviewed and approved by a contracted dietitian to ensure they are suitable for the elderly in residential care. Each resident is assessed by the senior RN on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. A copy of the nutritional profile is retained in the records and the kitchen is notified of any special food requests. Visual inspection of the kitchen evidences compliance with current legislation and guidelines. All kitchen staff have completed food safety training. Meals are provided at appropriate times of the day. Family/whanau interviewed report satisfaction with the food service provided.

Outcome 1.4: Safe and Appropriate Environment

The service have current building warrant of fitness. There have been no changes in the building that have required changes to the approved evacuation plan.

Outcome 2: Restraint Minimisation and Safe Practice

There is no restraint or enablers in use at the rest home. The rest home is designed to allow maximum freedom of movement while promoting the safety of residents. The service maintains processes for determining approval of all types of restraint and restraint processes. The policy requirements are implemented related to the use of enabler use. The previous corrective action has been completed.

Outcome 3: Infection Prevention and Control

Monthly infection surveillance data is recorded, collated and reported to the manager through the staff meetings. Analysis and evaluation of data is used to develop any corrective actions required, which are monitored in a timely manner.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	17	0	0	0	0	0
Criteria	0	39	0	0	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	33
Criteria	0	0	0	0	0	0	0	62

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

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 eight of eight residents report they receive full and frank information and open disclosure from the staff. The four of four residents' files sighted provide evidence of family/whanau communications. Residents and family members interviewed state they have the opportunity to talk to management or staff. All residents at the time of audit speak English. The service has policies and procedures in place for accessing interpreter services when this is required. The service has a number of multi-lingual staff. The Aged Related Residential Care (ARRC) requirements are met.

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. Complaints forms are accessible at the entrances to the service. The eight of eight residents report that these are easily accessible if they require them. Written and verbal complaints are recorded in the log.

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. The register records the date the complaint is received, summary of the complaint, actions, follow up and signature when closed. The complaint log records minor complaints all of which have been satisfactorily resolved. The service conducts an annual complaints analysis (sighted for the 2013 complaints) which summaries and looks for any trends. Most complaints

are of a minor nature (eg, regarding lost items that had since been found and some regarding the food and laundry service). In 2013 there had been two complaints that involved the Health and Disability Commissioner (HDC), both of these are satisfactorily resolved. There is one ongoing external complaint at the time of audit that is currently being investigated by the district health board.

The ARRC requirements are met.

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

The organisation's purpose, values, scope, direction and goals are identified in the business plan which is directly linked to quality and risk plans. Plans are reviewed at least annually to ensure services are planned, co-ordinated and appropriate to meet the needs of residents. The sighted mission statement is to provide a quality, homely environment which enables the frail elderly and confused to live in an atmosphere of respect and friendliness and have their physical and psychological needs met regardless of culture, race or creed. The objectives, goals and actions are assessed and established by management on a yearly basis. The service has an annual quality improvement plan (November 2013 to November 2014 sighted).

The facility is managed by an owner/manager. The owner/manager is suitably qualified and experienced with authority, accountability, and responsibility for the provision of services. The owner/manager has managed aged care services for over 14 years. The facility is a member of aged care organisations, with the owner manager or other members of the management team attending their forums. The owner/manager has attended over 8 hours education in the past 12 months related to the management of aged care services (approximately 40 hours to date in 2014). The owner/manager is supported by a management team and a senior registered nurse (RN).

The ARRC requirements for rest home level of care are met.

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The sighted quality and risk management guidelines identify objectives and action planning and support to reach identified goals. Strategic directions are based on the service's mission and values. There are strategic objectives for the service, human resources management, financial management, facility and infrastructure and new developments. The organisation has a quality and risk management system which is understood and implemented by staff, as confirmed at interview with six of six staff.

The organisational policies and procedures are developed by an aged care consultant. The policies and procedures are aligned to meet the requirements of legislation, and are reviewed annually. The service has personalised the documents to meet the needs of their rest home. There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures are accessible by staff. The obsolete documents are archived on sight.

Key components of service delivery are explicitly linked to the quality management system. The quality and risk management system is closely linked with the health and safety, complaints management and infection control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of the service delivery. There is an additional monthly audit report analysis of the internal audits conducted for that month. The analysis includes the review of the purpose of the audit, frequency of the internal audit and if this needs to be amended, the procedure for the audit, a summary of the finding and discussions related to the findings. This analysis is discussed at the staff meetings.

Corrective action plans are developed from identified areas of improvement through the internal audits, hazards, incident forms, satisfaction surveys and the complaints management process. Corrective action request forms and the findings on the internal audits document the findings, and compare the findings to the previous audit, comments and recommendations. A re-audit of the issue is conducted to review if the actions implemented are effective in minimising or eliminating the area of concern. The action sheet for the internal audit summarises the outcome score, the outcome score of the previous audit, recommendations, actions to be taken and who is responsible for the follow up, an analyses of whether issues have improved or worsened since the previous audit and a completion date where the implemented actions are reviewed. Outcomes and action plans are discussed at the staff meeting.

Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The risk management plan for November 2013 to November 2014 is sighted. The risk management plan identifies the area of risk, who is responsible for monitoring, the methods and resources implemented to minimise the risk and status of the ongoing monitoring. The risk is classified by the likelihood of the risk occurring and level of impact of the risk (eg, rated from critical to low). There is an annual audit follow-up of the risk management plan to ensure any issues documented are dealt with appropriately.

The relevant ARRC requirements are met.

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): <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: 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 1.2.3.9 (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:

There was an area of improvement at 1.2.4.4 to ensure incident and accident forms are completed to identify family/whanau notification is documented. The 10 of 10 incident and accident forms sighted document that the relative has been notified.

Health and Safety policy identifies the statutory and regulatory obligations in relation to essential notification reporting. A serious harm notification form and report template is available. Staff understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The manager reports that there have been no major incidents or essential events that have required reporting to the relevant authority.

A review of 10 incident and accident reports from May 2014 identifies a wide range of incidents are reported by staff and data is collected to identify trends. If an area for improvement is identified through the events reporting process and complaints or internal audits, this is addressed through a corrective action plan. Interviews of three care staff (one senior caregiver and two caregivers) confirm staff have a good understanding of reporting of adverse events.

The ARRC requirements are met.

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

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

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:

Professional qualifications are validated, including evidence of registration and scope of practice for the professional staff. Annual practising certificates are sighted for all staff that require them.

There are processes implemented for the appointment of appropriate staff to safely meet the needs of residents. The five of five staff files reviewed demonstrate appropriate recruitment and employment processes. These include recruitment and employment processes for advertising, interview process, reference checking, police vetting and qualification validation. There is a performance appraisal system, which is conducted at least annually for all staff. The newer staff also have a performance review after the first three months of employment.

New staff receive an orientation/induction programme that covers the essential components of the service provided. The staff files reviewed evidence an orientation and the three of three caregivers interviewed confirmed they received an orientation that was effective in preparing them to work at the service.

There is a system in place to identify, plan, facilitate, and record ongoing education for staff to provide safe and effective services to the residents. The completed annual training time table for 2013 is sighted, as well as the planned education for 2014. The education provided in 2013 is appropriate to rest home level of care. The Aged Care Education (ACE) training programme is the primary education focus for the caregivers. All caregivers who do not have a national qualification are required to commence the ACE programme within three months of employment.

The eight of eight residents interviewed report satisfaction with care provided.

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

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

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

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:

Good employer policy sighted includes a policy statement confirming safe employment and skill mix of staff. It also includes details and requirements for staffing to meet contractual requirements. The service has staffing that is above the minimum contractual requirements.

There is a manager on duty in the mornings Monday to Friday. The rosters confirm the following:

- morning shift – there is one RN and four caregivers
- afternoon shifts there is one RN and two caregivers
- on night shift there are two caregivers.

There is a RN on call afterhours. There are adequate laundry, cleaning and kitchen staff to meet the needs of the resident. There are two activities coordinators, one working five days a week and the other working four days a week.

The ARRC requirement for rest home level of care is met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c.i; 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:

Service delivery documentation is overseen by the senior RN. Documentation is part of the audit process and reviewed at regular intervals to ensure documentation is completed within required timeframes. In the four files reviewed there is evidence of initial assessments and care plans being completed and clinical risk tools being reviewed in the required timeframes.

Beachfront Rest Home has not commenced using interRAI computer programme for assessments but the senior RN is in the process of completing the training. The long term care plan template is personalised, reviewed and amended within required timeframes.

The senior RN (SRN) reports there is a process for six multidisciplinary resident reviews or earlier if required. There is evidence in the four files reviewed that family/whanau are involved in all areas of care management. Beachfront Rest Home have the services of a GP who visits twice weekly or at other times if required. The GPs share on call cover 24 hours a day, seven days a week (24/7), for all residents.

The SRN reports that Community Geriatric Services from the Waitemata District Health Board (WDHB) visit as required. Referrals are made to a dietitian for any unexplained weight loss.

The eight residents interviewed are very positive about the staff, GP and all aspects of care. The five clinical staff interviewed (one senior caregiver, two caregivers, one activities co-ordinator and one cook) report that they are kept up to date with all clinical changes. The previous corrective actions have been completed.

Tracer Methodology Rest Home Level Care:

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

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

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

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

Attainment and Risk: FA
Evidence: <p>In the four files reviewed there is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are evaluated set required timeframes to ensure residents' desired outcomes are being met.</p> <p>The SRN reports on interview that she ensures the staff are informed of the care needs of new residents at handover and any changes as required. This includes falls assessments, medication changes and challenging behaviour.</p> <p>Resident and family report on interview they are satisfied with the care they receive and any changes that are required.</p> <p>The five clinical staff interviewed report they are informed of any care plan changes at hand over and have relevant in-service education as required.</p>

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

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

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

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: <p>There is one activities coordinator and a qualified diversional therapist who work a total of 60 hours each a week employed at Beachfront Rest Home. Activities are available for all residents over seven days a week as the caregivers undertake activities during the hours when the activity staff are not on site.</p> <p>The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents. During interview the activities coordinator reports that it is important to have activities at similar times as the residents appreciated the routine.</p> <p>External visits for the residents include picnics, beach trips and van trips. Schools in the community attend the facility to undertake community service weekly. The eight residents report on interview that the activities are positive and include walking and music.</p>

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: <p>Individual short term care plans are seen for wound care, infections and weight loss. These are kept in the resident's folder and each shift documentation is made in the file. These are transferred to progress notes when completed or transferred to the long term care plan.</p> <p>Long-term care plans are reviewed every six months or earlier as required. Evidence of this was sighted in the four files reviewed. Progress notes are signed each duty by caregivers. Evidence is seen of the family/whanau involvement in the care reviews. In all four files reviewed evidence is seen of documentation if an event occurs that is different from expected and requires changes to service. There is a separate page to document when a family member has been contacted and the eight residents interviewed report that they are given the opportunity to be involved in all aspects of care and reviews.</p> <p>The five clinical staff interviewed have knowledge of the care plan documentation requirements.</p> <p>The previous area for improvement relating to residents files not being evaluated within required timeframes has been addressed.</p>

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

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: FA

Evidence:

Beachfront Rest Home uses the blister pack medicine system whereby medicines are delivered weekly except for pro re nata (PRN) medication which are delivered as required. When the blister pack medicines are delivered they are checked by the SRN and evidence is seen of the signing sheet. There are controlled drugs on the premises and all processes comply with the legislative requirements.

There is evidence in all eight files reviewed that medication charts are reviewed three monthly by the GP or as required.

Standing orders are not used at this facility.

Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The SRN reports that the GP works with the pharmacy but he/she is responsible for all medicines administered to his residents. If medicine is brought in by family this is approved by the GP and he/she charts on the medication sheet.

The SRN and competent caregiver are responsible for all medication rounds. Evidence is seen of the designated staff having up to date competency for medicine management and administering medicines. The caregivers who administer medicine report on interview they undertake annual competency and have the support of the SRN with any medicine queries. The residents report on interview they discuss with the doctor any medicine requirements and are informed of changes.

There is no self-administration of medicines at Beachfront Rest Home

Medicine sheets are signed in ink as required following administration.

The previous area for improvement relating to evidence of medication sheets being reviewed has been addressed.

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

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

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

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

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: FA

Evidence:

Beachfront Rest Home operates a seasonal menu cycle approved by a dietitian (sighted). An individual dietary assessment is completed on admission which identifies individual needs and preferences. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans.

The service is managed by a two cooks over seven days. Evidence is sighted of meal planning, cleaning routine and audit requirements being completed. Both cooks are up to date with their food safety certificate. Evidence is seen of attendance at annual update education on infection control and first aid. The cook reports on interview that she is supported by management with food supplies and understands the individual requirements of the residents.

If residents require assistance with feeding a caregiver is available to assist.

Resident satisfaction surveys which are completed annually provide evidence of satisfaction with meals provided.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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 building warrant of fitness expires 28 May 2015. There are no changes to the layout of the building that has affected the approved evacuation scheme.

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: The previous audit identified an area of improvement to ensure all policy requirements are implemented related to enabler use. The previous

audit identified that written assessment form found in policy is not being used by the service and the use of the bedside loop is not identified on the residents' care plans. The service have implemented process to ensure the assessment form is utilised where appropriate. At the time of audit there is no enabler or restraint use.

The service actively tries to minimise any restraint use. All residents are independently mobile with the use of a walker as required. Currently there are no restraints or enablers in use. An in-service staff education session on restraint and challenging behaviour was held in February 2014. Staff are focussing on de-escalation and calming techniques. Clinical staff interviewed demonstrate knowledge and understanding about the requirements of restraint minimisation and the use of the appropriate assessment forms.

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>

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA
Evidence:

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint 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 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

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

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

Attainment and Risk: FA
Evidence: The infection prevention and control co-ordinator, with guidelines from the organisational policies, defines the reporting requirements and determines the type of surveillance required. There is monthly surveillance reporting of infections at the monthly staff meeting. The surveillance undertaken is appropriate for the size of the facility. The staff interviewed confirm that surveillance information is discussed at the staff meetings. Surveillance results are used to identify infections or events. Analysis includes if infections are affecting one or multiple residents, what organism was identified and the possible causes. If infection rates are higher than expected, then recommendations are made and action plans are developed to help lower the rates. The infection data form has actions, interventions and evaluation of the actions for each individual resident with an infection. The infection data is evaluated and trends analysed. The surveillance data indicates there are one to two infections each month to date in 2014. The infection analysis for April 2014 records two urinary tract infections, both are associated with each other and no trend has been identified. The analysis records that staff encourage residents to drink plenty of fluids and ensure the resident has good hand and perennial hygiene. The surveillance results are summarised at the staff meetings.

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>