# Lady Joy Home Limited

## Current Status: 20 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

Lady Joy Rest Home provides care for up to 31 residents who require rest home level care. There were 23 residents on the day of this audit. The facility is operated by Lady Joy Home Limited. This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract. Residents and family interviewed reported that the care provided is very good.

Two areas requiring improvement identified at the last certification audit relating to documented care plan evaluations and the safe storage of chemicals have been addressed.

Areas requiring improvement at this surveillance audit relate to current food safety training for the cook, reassessment for one resident and medication documentation.

## Audit Summary as at 20 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 |
|  | 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 20 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. |

### Organisational Management as at 20 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Continuum of Service Delivery as at 20 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 20 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. |

### Restraint Minimisation and Safe Practice as at 20 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. |

### Infection Prevention and Control as at 20 June 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:** | Lady Joy Home Limited |
| **Certificate name:** | Lady Joy Home Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health Audit (NZ) Limited |

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Lady Joy Rest Home |
| **Services audited:** | Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 20 June 2014 | **End date:** | 20 June 2014 |

|  |
| --- |
| **Proposed changes to current services (if any):** |
| Two single bedrooms created from an office. |

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 23 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 4 |
| **Other Auditors** | XXXXX  | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 3 |

## Sample Totals

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 9 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 25 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## Declaration

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

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of Health Audit (NZ) Limited | Yes |
| b) | Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health Audit (NZ) 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 Audit (NZ) Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health Audit (NZ) Limited has finished editing the document. | Yes |

Dated Thursday, 26 June 2014

## Executive Summary of Audit

|  |
| --- |
| **General Overview** |
| Lady Joy Rest Home provides care for up to 31 residents who require rest home level care, and there were 23 residents on the day of this audit. The facility is operated by Lady Joy Home Limited. This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract. Residents and family interviewed reported that the care provided is very good. Two areas requiring improvement identified at the last certification audit relating to documented care plan evaluations and the safe storage of chemicals have been addressed. Areas requiring improvement at this surveillance audit relate to current food safety training for the cook, reassessment for one resident, and medication documentation.  |

|  |
| --- |
| **Outcome 1.1: Consumer Rights** |
| The service provides an environment conducive to effective communication. Residents and family members interviewed report that services are provided in a manner that respects residents’ rights and facilitates informed choice. They report that they are happy with the service provided and that staff are providing care that is appropriate to their needs. There is documented evidence of notification to family members following adverse events and any significant change in a resident's condition. The Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is displayed along with complaint forms.The nurse manager/owner is responsible for the management of complaints. There has been one verbal internal complaint and a coroner’s inquiry since the last audit.  |

|  |
| --- |
| **Outcome 1.2: Organisational Management** |
| Lady Joy Home Limited is the governing body and is responsible for the service provided at Lady Joy Rest Home. Planning documents reviewed include a business plan, as well as a philosophy of care and core values for the service. Systems are in place for monitoring the service provided at Lady Joy Rest Home, including regular monthly reporting to staff via staff meetings. The purpose, values, scope, direction and goals of the organisation are defined and reviewed. Goals and future developments are a component of annual business planning. The business has been owned and managed by the two directors/owners for 14 years. One owner being the facility manager and the other the nurse manager.There is a documented quality and risk management system in place, including an internal audit programme. Quality improvement data is collected, collated, and analysed to identify trends. Corrective actions are developed and implemented, when required. Reporting of quality improvement data occurs via scheduled staff meetings.There is a well-documented and implemented adverse event reporting system. Essential notifications are made where required. Incidents are managed in an open and transparent manner. Collated adverse event data is communicated to staff. Annual practising certificates are current for all staff and contractors who require them to practice. Lady Joy Rest Home employs a nurse educator who is responsible for the development and delivery of staff training. The planned training programme is comprehensive and fully implemented, apart from ongoing food safety training for the cook. Staff are supported to complete Careerforce education. Staff performance is monitored through the completion of defined competencies and annual performance appraisals. There is clearly defined rational for staffing which ensures adequate numbers of skilled staff are on duty at all times. The facility manager and nurse manager work full time and are both available after hours, if required. Care staff interviewed report there is adequate staff available and that they are able to get through their work.There is one area identified as requiring improvement relating to evidence that the cook has current training in food safety. |

|  |
| --- |
| **Outcome 1.3: Continuum of Service Delivery** |
| The long term care plan is developed from the initial assessments and risk assessments. The required clinical care is recorded. Support and interventions by the service provider are documented and record the required encouragement, direction, or supervision of a resident completing their own personal cares. Staff utilise written progress notes to record any current resident issues. The general practitioner’s notes are current.Activity plans reflect everyday living and residents have opportunity to participate in community activities. The activities for residents are planned and facilitated in such a manner that it maintains strengths and interests of the residents. Short term care plans and amendments to the long term care plan reflecting changes in condition. The service complete annual medicines management training for staff. The facility does not support self-administration of medicines for residents. Special dietary needs of residents are being identified on the dietary assessments. Fluid and nutritional needs are provided for by the service. Residents that need additional nutritional requirements or special diets, have their needs met. There are requirements for improvement relating to needs assessments, restraint assessment and medical reviews. |

|  |
| --- |
| **Outcome 1.4: Safe and Appropriate Environment** |
| The building has a current warrant of fitness. There have been no alterations to the building since the last audit. The area requiring improvement from the last audit relating to the safe storage of chemicals is now fully attained.Two single bedrooms have been created from an office. The rooms meet requirements, including appropriate heating and call bells. |

|  |
| --- |
| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has one resident utilising restraint and two residents using enablers. There are systems in place to ensure the use of restraint is actively minimized. Education and training relating to restraint minimisation and safe practice and de-escalation techniques occur annually. |

|  |
| --- |
| **Outcome 3: Infection Prevention and Control** |
| The organisation carries out surveillance that is appropriate to the size and complexity of the service and the level of care providedThe results of surveillance are used in assisting infection prevention and reduction. Findings are collected, evaluated and reported to staff on a monthly basis.The infection control programme is clearly documented and is suitable for a rest home setting. Infection data is analysed for trends and communicated to staff. The use of antibiotics is monitored. There have been no infection issues or out breaks since the last audit. |

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 14 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 1 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 59 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management  | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The cook does not have a current certificate in food safety. It is acknowledged that during the audit the cook is booked in to attend a food safety course on the 9 July 2014. | Provide evidence that the cook has completed a food safety course. | 90 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | The resident’s needs changed after having had a fall, however the resident was not re-assessed by the NASC team in order to ensure all the needs of the resident were met and the resident’s restraint review was not completed at the nursing or the medical review. | The service to provide services within the required timeframes or when the resident’s condition change in order to ensure safe and appropriate care. | 30 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management  | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.6 | Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | Three of ten residents do not have timely reviews (three monthly) of their medicines charts completed by the general practitioner. | All resident to have a three-monthly medical review completed by the general practitioner | 30 |

## 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:** |
| Open disclosure procedures are in place to ensure staff maintains open, transparent communication with residents and their families. Five residents' files reviewed provide evidence that communication with family is being documented in residents’ files in family/whanau communication sheets. On admission the resident and their family are given information and a discussion is held around any questions they may have. There is evidence of communication with the GP and family following adverse events, which is recorded on the accident/incident forms, and in the individual resident's file. Five residents and three family members interviewed confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care. The nurse manager/registered nurse (RN) advises access to interpreter services is available if required via age concern advocacy services. Staff members interviewed advise they currently have no residents who require interpreters.Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed). The district health board contract 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 appropriate complaints management system in place. Residents are advised on entry to the facility of the complaint processes and the Code and this is recorded in the Lady Joy information booklet. The complaint forms and the complaint policy are displayed at entrance to the facility. Five of five residents and three of three family interviewed confirm an understanding and awareness of the complaints processes.A complaints register is maintained and records one verbal internal complaint since the last audit. The nurse manager reports there has also been a coroner’s inquiry following the death of a resident in early 2013, as a result of a fall. A letter from the coroner’s office dated 18 February 2014 was reviewed and states that the coroner is currently finalising their inquiry.The district health board contract 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):**  *(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:** |
| Systems are established and maintained which define the scope, direction and goals of the facility and monitoring and reporting processes against these. A ‘Business Plan 2014’ is reviewed that includes a strategic plan, mission, values statement, vision, purpose, swot analysis, strengths, weaknesses, and opportunities.Organisational performance is monitored through the facility manager/owner and the nurse manager/owner. The facility is managed by a suitably qualified and experienced manager who has been the facility manager for 14 years, and is supported by the nurse manager who is an experienced registered nurse with extensive aged care experience and has been in this position for 14 years. The nurse educator is responsible for the day-to-day management of the facility during the manager’s absence with support from the senior care giver. The district health board contract requirements are met.  |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The quality manual and quality and risk management plan is sighted and used to guide the quality programme and includes quality goals and objectives. There is an internal audit programme in place and completed internal audits for 2013 and 2014 are reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A Health and Safety manual is available that includes relevant policies and procedures.Clinical indicators and quality improvement data are documented and graphed and reviewed as part of this audit. There is documented evidence quality improvement data is being collected, collated and analysed and corrective actions are developed implemented, closed out and reviewed, including reporting on numbers of various clinical indicators and quality and risk issues to staff via monthly quality/infection control/health and safety/staff meetings. Minutes of meetings are given to staff who are not able to attend staff meetings. Staff interviewed report they are kept well informed of quality and risk management issues including clinical indicators. Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff signing sheet demonstrates staff have been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff interviewed confirm the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies in the staff room, via handover, and meetings. Health & Safety policies and procedures are available and staff are aware of and report hazards at the facility, when this is required. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.The district health board contract 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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The adverse event reporting system provides evidence of a planned and co-ordinated process. Adverse, unplanned or untoward events are recorded on an accident/incident form, sighted, which are then reviewed by the nurse manager, who follows up as required. Once the accident/incident form is completed it is entered onto an incident/accident monthly summary. Quality/infection control/health and safety/staff meeting minutes reviewed and demonstrate that quality and risk issues, including reporting on numbers of events is occurring at these meetings e.g. accident/incident/event reporting outcomes, complaints, audit outcomes, infection control, health & safety and restraint usage.There is an open disclosure policy. Five resident files reviewed provide evidence of communication with families following adverse events involving the resident, or any change in the resident’s condition and confirmed at family member interviews.Staff confirm during interview that they are made aware of their essential notification responsibilities through: job descriptions and policies and procedures. Policies and procedures comply with essential notification reporting e.g. health and safety, human resources, infection control.The district health board contract 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:** PA Low |
| **Evidence:** |
| Written policies and procedures in relation to human resource management are available and are reviewed. The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority which were reviewed on five of five staff files reviewed, along with employment agreements, reference checking, completed orientations and competency assessments (as appropriate). Current practising certificates are sighted for the nurse manager, nurse educator, pharmacist, podiatrist and the GPs that visit the facility.An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The orientation process, including completion of competencies and staff performance is reviewed at the end of the orientation period. Orientation for staff covers the essential components of the service provided including the quality improvement plan; policies and procedures; health and safety requirements; the physical layout of the facility; the authority and responsibility of their individual positions; the organisation’s vision, values and philosophy.The human resource management system provides for the implementation of processes both at the commencement of employment and on-going in relation to staff education. Careerforce education is provided and staff and are supported to complete these education programmes. All staff have completed the ACE dementia specific modules. A nurse educator is employed to provide education. The education programmes for 2013 and 2014 is reviewed and meets the requirements of the ‘Health and Disability Sector Standards’ and the district health board contract. Education records and five of five individual staff records of education are reviewed and are maintained for each staff member, and provide evidence that staff are provided with a comprehensive education programme with competency assessments included. Performance appraisals are current in five of five staff files reviewed. All staff have current first aid certificates.There is evidence in the cook’s file that they have completed a certificate in food safety in 2009, however there is no evidence to indicate that the cook has received ongoing training in food safety. This requires an improvement. (See criterion 1.2.7.5, and Link to 1.3.13.)Not all district health contract 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):**  *(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:** PA Low |
| **Evidence:** |
| There is evidence in the cook’s file that they have completed a certificate in food safety in 2009, however there is no evidence to indicate that the cook has received ongoing training in food safety.  |
| **Finding:** |
| The cook does not have a current certificate in food safety. It is acknowledged that during the audit the cook is booked in to attend a food safety course on the 9 July 2014. |
| **Corrective Action:** |
| Provide evidence that the cook has completed a food safety course. |
| **Timeframe (days):** 90 *(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 rostering policy reviewed includes a clearly documented staffing rationale for determining service provider levels and skill mixes in order to provide safe service delivery at Lady Joy Rest Home, that is based on best practice. The roster is reviewed and the minimum amount of staff is provided during the night shift and consists of one care giver on duty. The nurse manager is on call after hours and lives approxiamaty 100 metres from the rest home. All care staff interviewed report there is adequate staff available and that they are able to get through their work.The nurse manager during interview reports the care giver on night duty is able to care for the resident who’s condition has changed and who is more dependent. The nurse manager reports there are two care staff on duty until 12 midnight (confirmed on roster) and the night care giver is able to turn the resident on their own. (See link to criterion 1.3.3.3).Residents and family members interviewed report there is enough staff on duty to provide them and their relative with adequate care. Visual observations during this audit confirm adequate staff cover is provided.The district health board contract requirements are 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; D16.5ci; 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:** PA Low |
| **Evidence:** |
| The residents receive competent services, however it is not certain that all resident’s needs are being met.Residents confirm involvement throughout service delivery and staff are suitably qualified to render the services. All sampled resident files evidence evaluation and review of the resident care plans. The nurse manager completes an admission assessment on all new residents and the admission assessment is utilised by the service as the initial care plan during the first three weeks after admission, sighted and confirmed at the nurse manager and care giver interviews. The long term care plan is developed from the information gathered at admission, the initial assessments and risk assessments.The GP reviews all residents three monthly or when the resident's condition require review, sighted three monthly reviews for five of the five resident files sampled. There is a requirement for improvement relating to the resident needing to be re-assessed regarding the levels of care and regarding the restraint assessment not being completed within the required timeframes.The district health board contract requirements are not fully metTracer methodology: XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

|  |
| --- |
| **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:** PA Low |
| **Evidence:** |
| The residents receive competent services; however it is not certain that all resident’s needs are being met. Residents confirm involvement throughout service delivery and staff members are suitably qualified to render the services. |
| **Finding:** |
| The resident’s needs changed after having had a fall, however the resident was not re-assessed by the NASC team in order to ensure all the needs of the resident were met and the resident’s restraint review was not completed at the nursing or the medical review. |
| **Corrective Action:** |
| The service to provide services within the required timeframes or when the resident’s condition change in order to ensure safe and appropriate care. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents, family and the GP confirm they are satisfied with the service. Five residents' files sampled evidence the care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the resident. The required clinical care is recorded. Support and interventions by the service provider are documented and record the required encouragement, direction, or supervision of a resident completing their own personal cares. Staff utilise written progress notes to record any current resident issues. The general practitioner’s notes are current. Visual inspection of the service evidences adequate continence and dressing supplies in accordance with requirements of their Service Agreement. Five of five residents and three of three family members interviewed confirm the care and treatments they are receiving meet their needs.The district health board contract requirements are met. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Activities are appropriate to the service setting, needs and age and culture of the residents. Activities plans reflect everyday living and residents have opportunity to participate in community activities. The activities coordinator records attendance at activities and prepares a monthly activities programme. Interview with activities coordinator confirms participating in satisfaction surveys and resident meetings. The activities for residents are planned and facilitated in such a manner that it maintains strengths and interests of the residents. The residents and family interviewed confirm activities are meaningful and varied.The district health board contract requirements are met. |

##### 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:** |
| Care plans are reviewed every six months, or as required and reviews are comprehensive. The resident reviewed has short term care plans and amendments to the long term care plan reflecting changes in condition, sighted and confirmed at the nurse manager interview. The service ensures where progress is different from expected, they respond by documenting changes to the care plans however restraints and NASC assessments are not always reviewed in a timely manner (refer to criterion 1.3.3.3).The previous requirement relating to care plan reviews not being comprehensive is now fully implemented.The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Staff members that are responsible for medicines management complete competencies to ensure safe and appropriated medicines management processes. The service has 10 care givers and one nurse manager who administer medicines. Medicines management competencies are signed off annually.The most recent medicines management training was completed on 12 February and 16 March 2014. The facility does not support self-administration of medicines for residents, confirmed at resident, family and the nurse manager interviews. There was no evidence of any residents self-administering medicines during the time of the audit. The afternoon medication round was observed. At the time of the audit the service had no controlled drugs. Fridge temperatures are monitored, CD if used, the clinical manager is responsible for medication reconcilliation. Medicines are stored in a safe and appropriate manner. Medicines management information is recorded to a level of detail which includes resident’s medicines charts being legible, the general practitioner signing and dating all new entries as well as discontinued medicines. Allergies and sensitivities are recorded, each resident has photo identification on their medicines chart and medicines reconciliation occurs however, not all residents whose charts were reviewed had timely reviews of their medicines charts completed by the general practitioner.The district health board contract requirements are not fully met. |

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Resident’s medicines charts are legible, the general practitioner signs and dates all new entries as well as discontinued medicines, allergies and sensitivities are recorded, each resident has photo identification on their medicines chart and medicines reconciliation occurs however, not all residents who’s charts were reviewed had timely reviews of their medicines charts completed by the general practitioner. |
| **Finding:** |
| Three of ten residents do not have timely reviews (three monthly) of their medicines charts completed by the general practitioner. |
| **Corrective Action:** |
| All resident to have a three-monthly medical review completed by the general practitioner |
| **Timeframe (days):** 30 *(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:** |
| Residents' nutritional needs are catered for as each resident has a nutritional assessment completed at admission, confirmed at the RN, and the cook interviews. Special needs for residents are being identified on the dietary assessment. Fluid and nutritional needs are provided for by the service. Residents that need additional nutritional requirements or special diets, have their needs met by the service keeping information regarding their needs at hand in the kitchen to ensure specific nutritional needs are catered for. Menu’s are planned and reviewed by an independent dietitian. Visual inspection of the kitchen confirms appropriate food services. Interviews with residents and their family members confirm they receive food services in line with legislative requirements. Satisfaction surveys evidence residents are satisfied with food services. Food procurement and storage are according to legislative requirements. food temperatures, fridge and freezer temperatures are recorded and within required requirements.The cook has not completed food safety training (refer to criterion 1.2.7.5).The district health board contract requirements are met. |

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

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

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

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

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

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

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

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

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| A Building Warrant of Fitness is displayed at the front entrance that expires on 22 June 2015.Residents are provided with the safe and appropriate environment. On-going maintenance/refurbishments and compliance checks ensures the environment remains safe and fit for purpose. External areas are well maintained. Two single bedrooms were created from an office in the period between the surveillance audit of May 2011 and the last certification audit of November 2012. The manager advises these rooms were reviewed at the last audit, however the last report does not reflect this including the stated bed numbers. The rooms are reviewed again at this audit and meet the requirements, including appropriate heating and call bells.  |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

#### Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The area requiring improvement from the last audit relating to the safe storage of chemicals is addressed. Chemicals are stored in a locked cupboard in the laundry. There are adequately documented policies for the management of cleaning and laundry services. The provider has designated staff for cleaning and laundry. The effectiveness of laundry and cleaning processes are monitored. Last audit was completed 17 June 2014.The district health board contract requirements are met. |

##### Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

|  |
| --- |
| **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:** |
| The restraint register show that there is one residents using restraint and two enablers used in the facility. The resident file reviewed for restraint had consent signed, risks are identified and were reviewed in a timely manner. The service provides on-going training to staff, in de-escalation techniques and the management of challenging behaviour. The clinical manager and care givers confirm they monitor the restraint, sighted records. Interviews with family and the GP confirm they are satisfied that restraint is used in a safe and appropriated manner.The district health board contract requirement is met. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The type of surveillance undertaken is appropriate to the size and complexity of the organisation. The infection control co-ordinator completes an infection monitoring monthly report with relevant data and collates data monthly into a resident infection assessment form, that is analysed monthly. The rate of infection by bed numbers is reported as a clinical indicator to staff at the staff meetings, minutes sighted, and at handover between shifts. Review of data records for the last 12 months indicate that infection rates are low with no adverse trends identified. Audits are completed on a regular basis, sighted. Standard definitions are used to identify infections for surveillance. |

##### 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.)* |