# Eastern Services Limited

## Current Status: 15 July 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

Eastern Services Limited is a family owned business that operates the Gulf Views Rest home in Howick. The service provides rest home level of care for up to 45 residents, with 41 beds occupied at the time of the surveillance audit. At the previous audit the service had four areas requiring improvement; these have now been addressed. At this unannounced surveillance audit, there are no new areas identified as requiring improvement.

The service has a clearly documented purpose, values, scope, direction, and goals that are regularly reviewed. Quality improvement data is collected, analysed and evaluated and the results communicated to staff and, where appropriate, residents. Key components of service delivery are linked to the quality management system. The quality plan clearly identifies objectives, strategy, performance indicators, measurement and frequency of monitoring for all quality indicators and risks.

Services offered at Gulf Views Rest Home meet the requirements and timeframes for assessment, care planning, review, evaluation and care provision. The service provides planned activities which ensure what is offered is meaningful to the resident and allows them to maintain or improve their strengths, skills and interests. The service implements medicine management process as described in policy and procedures to ensure residents receive medicines in a safe and timely manner. Residents are provided with food, fluid and nutritional services that are assessed by a qualified dietitian as being suitable to meet all nutritional needs. The service has established systems for the minimising the use of restraint, and have no reported restraint or enabler use.

There are systems in place for infections prevention and control. 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.

## Audit Summary as at 15 July 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 15 July 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 15 July 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. |

### Continuum of Service Delivery as at 15 July 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. |

### Safe and Appropriate Environment as at 15 July 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 15 July 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 15 July 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 4.2)

## **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:** | Eastern Services Limited |
| **Certificate name:** | Eastern Services Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | The DAA Group Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Gulf Views Rest Home | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 15 July 2014 | **End date:** | 15 July 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:** | 41 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 8 | **Hours off site** | 4 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 7 | **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** | XXXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 15 | Total audit hours off site | 10 | Total audit hours | 25 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 8 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 4 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 33 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXXX, Director of Christchurch 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 | Yes |
| b) | The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | The DAA Group 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) | The DAA Group Limited has provided all the information that is relevant to the audit | Yes |
| h) | The DAA Group Limited has finished editing the document. | Yes |

Dated Thursday, 31 July 2014

## **Executive Summary of Audit**

**General Overview**

Eastern Services Limited is a family owned business that operate the Gulf Views Rest Home in Howick. The service provides rest home level of care for up to 45 residentswith 41 beds occupied at the time of the surveillance audit. At the previous audit the service had four areas requiring improvement; these have now been addressed. At this unannounced surveillance audit there are no new areas identified as requiring improvement.

The service has a clearly documented purpose, values, scope, direction, and goals that are regularly reviewed. Quality improvement data is collected, analysed and evaluated and the results communicated to staff and, where appropriate, residents. Key components of service delivery are linked to the quality management system. The quality plan clearly identifies objectives, strategy, performance indicators, measurement and frequency of monitoring for all quality indicators and risks.

Services offered at Gulf Views Rest Home meet the requirements and timeframes for assessment, care planning, review, evaluation and care provision. The service provides planned activities which ensure what is offered is meaningful to the resident and allows them to maintain or improve their strengths, skills and interests. The service implements medicine management process as described in policy and procedures to ensure residents receive medicines in a safe and timely manner. Residents are provided with food, fluid and nutritional services that are assessed by a qualified dietitian as being suitable to meet all nutritional needs. The service has established systems for the minimising the use of restraint, and have no reported restraint or enabler use.

There are systems in place for infections prevention and control. 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.

**Outcome 1.1: Consumer Rights**

Communication is conducted in an open and frank manner that reflects the services policy of open disclosure. The service has access to an interpreting service as required.

Complaints are managed to meet policy requirements. At the time of audit there are no outstanding complaints.

**Outcome 1.2: Organisational Management**

The service has a clearly documented purpose, values, scope, direction, and goals that are regularly reviewed. The service is managed by a suitably qualified and experienced nurse manager.

The service has a quality and risk management system which is understood and implemented by staff. Quality improvement data is collected, analysed and evaluated and the results communicated to staff and, where appropriate, residents. Key components of service delivery are linked to the quality management system. The quality plan clearly identifies objectives, strategy, performance indicators, measurement and frequency of monitoring for all quality indicators. The service's policies and procedures are up to date and aligned with current good practice and legislative requirements.

Actual and potential risks are identified and documented in the risk register. The identified risks are monitored, analysed, evaluated, and reviewed, with actions implemented to reduce the risk. All adverse, unplanned, or untoward events are recorded through the incident/accident reporting system. Any adverse, unplanned, or untoward events including service shortfalls are reviewed and analysed in order to identify opportunities to improve service delivery.

Safe staffing levels and skill mixes are maintained by Gulf Views Rest Home to ensure the needs of the rest home level of care residents are met. Human resources management processes are implemented meet legislative requirements. There is a system in place to identify, plan and facilitate on-going staff education.

The previous area for improvement to ensure the archiving of files meets legislative requirements is now addressed and an area of improvement implemented since the previous audit.

**Outcome 1.3: Continuum of Service Delivery**

Services offered at Gulf Views Rest Home meet the requirements and timeframes for assessment, care planning, review, evaluation and care provision. This is confirmed during resident and family/whanau interviews. One area identified for improvement in the previous audit related to three monthly medical reviews is now fully attained.

The service provides planned activities which ensure what is offered is meaningful to the resident and allows them to maintain or improve their strengths, skills and interests.

The service implements medicine management process as described in policy and procedures to ensure residents receive medicines in a safe and timely manner. Staff who undertake medicine administration hold appropriate competencies for appropriate areas of administration. Medication management information is recorded to a level of detail that complies with legislation and best practice requirements. Currently no residents self-administer medications. Areas identified for improvement in the previous audit are now fully attained.

Residents are provided with food, fluid and nutritional services that are assessed by a qualified dietitian as being suitable to meet all nutritional needs. This includes additional or modified nutritional requirements and residents’ likes and dislikes.

**Outcome 1.4: Safe and Appropriate Environment**

The service has a current building warrant of fitness. There have been no changes to the building that have required changes to the approved evacuation scheme.

**Outcome 2: Restraint Minimisation and Safe Practice**

The service has no restraint or enabler use at the time of audit. Policies and procedures are available to all staff should restraint or enablers be required. Staff education is undertaken as part of orientation and as part of regular on-going in-service education. Staff are able to demonstrate their understanding of the restraint minimisation policy and procedures and the definition of an enabler.

**Outcome 3: Infection Prevention and Control**

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. Infection control monthly surveillance data is shared with staff and management via formalised meeting processes.

## **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 residents’ right to full and frank information and open disclosure from staff is documented in the open disclosure policy (sighted). The five of five incident/accident forms sighted have a section for contacting family. The family contact is recorded on incident forms, with email communications sighted with family for one of the incident forms sighted. The five of five residents and two of two family report that they are kept informed and that the nurse manager is available if they have any concerns.

Wherever necessary and reasonably practicable, interpreter services are provided. The service can access interpreter services through the DHB if required. At the time of audit all residents are English speaking. The service has a number of staff who are bilingual and can assist with resident communication if this is required.

The Aged Related Residential Care (ARRC) service agreement 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. There are complaints forms and a complaints box on both floors of the facility. These are easily accessible and provide support for residents who make a complaint. The three care staff interviewed (one RN and two caregivers) report that if a resident makes a complaint, they support the residents in doing this.

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. There is one recorded complaint for 2014 of a minor nature that was responded to and resolved within two days of the complaint being received.

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):**  *(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:**

The service is a family owned business. The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed as part of the annual business plan - last reviewed in 2014. The draft 2015 business plan identified that the business plan is due to be reviewed by the business managers, managing director and the nurse manager in October 2014. The business plan sets goals, action plans and how these are to be achieved for the upcoming year. Meeting minutes identify that progress against the business plan is discussed at two monthly quality meetings and management meetings which are attended by the owner/managing director.

The day to day clinical care management of the facility is undertaken by a nurse manager who is a registered nurse (current practising certificate sighted) and has been in the role for 20 years. The nurse manager has a job description that outlines the roles, responsibility and authorities for the provision of services. The nurse manager is part of a NZ aged care association and has attended over 8 hours education in the previous 12 months related to the management of aged care services. The nurse manager also attends ongoing education through the District Health Board (DHB) aged related residential care education forums. The nurse manager is the chairperson for the Auckland section of the New Zealand Nurses’ Organisation Gerontology Section. The nurse manager has been awarded the 2014 Health of the Older People Residential Care Award from the DHB. The business manager interviewed reports high confidence in the nurse manager’s ability to manage the service.

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):**  *(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 organisation has a quality and risk management system which is understood and implemented by staff. There is an internal audit system which staff assist with its implementation. The sighted internal audit schedule for 2014 includes the type of audit, when it is to be conducted and what staff member is responsible for completing the audit. The quality system includes resident satisfaction surveys (eg, food, activities and service delivery). The internal audits are conducted for all aspect of the service delivery and the environment. The organisation has a documented process for the quantifying and interpreting of the internal audit results. The results of the internal audits are fed back to staff and the business manager. Interviews with eight of eight staff members (one RN, two caregivers, one activities coordinator, one laundry worker, one cook, one kitchen assistant and one administrator) confirm their input, knowledge and understanding of the quality plan and quality and risk systems which are in place.

Five of the internal audits sampled for 2014 include the summary of the results, areas identified for improvement, actions taken, follow up and final sign off by the nurse manager when completed. The audits sample include records and archiving (January 2014), food satisfaction (February 2014), laundry services (March 2014), environment (May 2014) and activities programme (May 2014). Where there are areas for improvement identified from internal audits or satisfaction surveys, the corrective action plan addressing areas requiring improvement is developed and implemented. This is recorded on the internal audit form (confirmed for the five internal audits sighted).

Key components of service delivery shall be explicitly linked to the quality management system. The quality plan clearly identifies objectives, strategy, performance indicators, measurement, frequency and facilitator for all quality indicators. Quality indicators cover human resources management, environmental services, supplies and equipment, emergency services, security, cleaning, waste management, residential health and wellbeing, resident care planning, accidents and incidents, skin integrity, hearing and visual acuity, staff orientation, training and education, resident infection, cleaning and kitchen services, laundry services, medical waste, hairdressing, medical cover, resident interviews, peer reviews, pharmaceutical supplies, correct medicine use, drug information and education, occupational assessment/programme/education/referrals/records and physiotherapy assessment/treatment/records/mobility aids.

Quality improvement data is collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, residents. Meeting minutes sighted identify that all aspects of service delivery are discussed at monthly staff meetings and that quality improvement issues are discussed at residents' meetings as appropriate.

All policies sighted are up to date and aligned with current good practice in a manner that incorporates legislative requirements. As confirmed during interview with the nurse manager, policies are reviewed at a minimum of two yearly or if a change is required to meet updated practices or legislative requirements. Policies are discussed at monthly staff meetings as sighted in meeting minutes. Staff only have access to current versions of policies and procedures.

Actual and potential risks and hazards are recorded in the hazard register. The register identifies the risk, potential harm, rates the hazards, records if the hazard can be eliminated, isolated or minimised. The register includes the proposed actions for the management of the hazard or risk and the frequency of monitoring the hazard. Risks are shown for the service environment, funding, organisational, financial, information, environmental, clinical and strategic planning. Risks are reviewed at least annually at the management meetings.

The 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):**  *(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:**

As confirmed at interview, management understand their responsibilities with regard to reporting adverse or unplanned events and who notification must be made to for a serious adverse event.

Adverse events are recorded and reported. As sighted in five incident/accident forms sampled for March 2014 the incident/accident is investigated, analysed and corrective actions are put in place as appropriate. Information is used as an opportunity to improve service delivery and identified risks are managed appropriately. There is a monthly analysis and summary of the adverse events. The analysis of the March 2014 adverse events includes the trending of times that falls have occurred. The service implemented additional falls prevention sessions for the staff with the physiotherapist. The five of five residents and two of two family/whānau interviews confirm they are kept well informed of any adverse events and any follow up that is undertaken. Interviews with the eight of eight staff confirm they document all 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 staff members. Annual practising certificates (APCs) are sighted in the staff file for the registered nurse (RN) and enrolled nurse (EN).

There are adequate processes for the appointment of appropriate staff to safely meet the needs of residents as sighted in the four of four staff files reviewed (one RN, one EN, two caregivers). The processes implemented are reflective of good employment practice and meet legislative requirements.

The four of four staff files reviewed evidence that new staff receive an orientation that covers the essential components of service provision. The orientation and induction includes new staff being ‘buddied’ with experienced staff until the new staff member feels confident to perform a task. Interviews with eight of eight staff confirm their orientation and ongoing education is appropriate to the roles they undertake. The two caregivers interviewed are aware of, and demonstrate knowledge of, policies and procedures and the use of residents' care plans to guide the care provided.

The service has an annual education plan in place and staff appraisals are used to identify areas of education for individual staff to ensure they can provide safe and effective service delivery. Education records are kept up to date for all staff members. The in-service education programme is scheduled over a two year period to ensure that all contractual requirement contents are covered during the in-service programme. The in-service programme includes education on specific disorders, diseases and issues that affect the older person. Education topics include Health and Disability Services Advocacy (June 2014), infection control (May 2014), pain management (June 2014), Code of Conduct (March 2014), dementia (November 2013). The staff have access to national qualifications in the support of the older person and have access to ongoing education through the DHB and local hospice service.

Interviews with five of five residents and two of two family/whānau members confirm they are extremely happy with the care provision.

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery, which meets the contractual requirements for rest home level of care. The skills mix identifies that all shifts have a senior staff member who is competent to provide all required services. The nurse manager (RN) is on duty Monday to Fridays. The rosters sighted for the previous four weeks record the care staff as:

- morning shift, one RN on duty Monday to Friday (with a senior nurse on duty on the weekends), three caregivers and an additional caregiver from 7am to 10am to assist with the showers.

- afternoon shift, there is a senior nurse and one caregiver

- night shift there is one enrolled nurse (EN) and one caregiver.

The rosters record that leave is covered. The service has adequate activities, domestic, laundry and administration support to meet the needs of the residents and ensure service delivery. The five of five residents and two of two family/whānau members feel that all services are delivered in an appropriate and safe manner by well trained staff and that all their needs are met.

The ARRC requirements for rest home level of care 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.)*

#### Standard 1.2.9: Consumer Information Management Systems **(**HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

**Attainment and Risk:** FA

**Evidence:**

The previous area for improvement at 1.2.9.1 identified that “on the day of audit it was difficult to find files for residents who are no longer at the facility”. This is now addressed and an area of improvement implemented since the last audit. The service has conducted a review of the clinical records and archiving systems. The sighted archives are securely stored and retrievable. There is a system in place for the confidential destruction of records. An internal audit of the clinical records and archiving (January 2014) records that all areas met the required standards for records management.

##### **Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)**

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

**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:** FA

**Evidence:**

A review of five of five resident files identifies that each stage of assessment, planning, evaluation and review is undertaken by a registered nurse (RN). Interviews with two of two caregivers confirm they have involvement in care planning as appropriate. The RN has completed interRAI training and is currently using this assessment base for new residents. One of the five files reviewed was completed using interRAI assessments. All staff have access to a comprehensive education programme both on-site and off-site.

Interviews with five of five residents and two of two family/whanau members confirm they are very happy with the care provided.

In five of five file reviews it identifies that initial assessments and a short term care plan are completed on the day of entry to the service. A long term care plan is put in place within three weeks. Appropriate assessment tools are used including fall risk assessments, pain assessments, continence, dietary, skin integrity and activities of daily living. Appropriate interventions are documented and used by staff to ensure resident services are put in place to meet their needs. Care planning is reviewed at least six monthly as well as an annual multidisciplinary review being undertaken in-between assessments. Additional assessments are conducted if there is a change in the resident’s condition at any time.

Documentation in five of five file reviews identifies the GP admits residents within the required timeframe to meet district health board contractual requirements. Three monthly reviews are documented and it is clearly identified that residents are stable. If any issue or concerns are voiced the GP reviews the resident as required. One area identified for improvement in the previous audit is now fully attained.

During interview with the GP he confirms that services are co-ordinated to promote continuity of care for residents. Progress notes are updated at least weekly to meet contractual requirements. If there are any issues or concerns about a resident a per shift entry is made in the progress notes. It was discussed with the RN and nurse manager on the day of audit that it is good practice to make at least a daily entry into the residents’ notes. They stated they would consider a change to policy.

Adequate information is reported during each shift handover, in the resident's progress notes and in the communication book to ensure resident's needs are met and that any concerns or issues are discussed and identified.

Tracer methodology – rest home resident:

*XXXXXX This information has been deleted as it is specific to the health care of a resident*.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

In the five of five resident file reviews the interventions shown on the care plan are congruent with assessment findings and requests made by other health care providers. Interventions are individualised to meet each resident’s needs, they are resident centred and easy to read. Examples sighted include a resident who had three falls in less than six months had a falls risk assessment review and hip protectors are now used. Another resident with a body mass index of 19.2 has their weight monitored weekly and have been commenced on a food supplement to ensure their body mass index does not decrease as it is at the lower end of the normal weight scale.

One resident’s file reviewed identifies that suggestions made by the Mental Health Services of Older People (MHSOP) team, the psychogeriatrician and the dermatologist have been followed up and the resident has better control of symptoms. Regular blood tests are undertaken and monitored by the GP. The GP states during interview that all his instructions are followed up accordingly by staff.

The RN interview confirms that she monitors follow up actions for all residents and that staff are informed during the per shift handover, in the progress notes and in the communication book if any changes to service delivery are required. This is confirmed in documentation sighted and during staff interviews.

Resident and family/whanau interviews confirm that services provided are meeting resident needs. One family/whanau member stated “the care provided is of a very high level and much better than they ever expected”. No negative comments were received on the day of audit.

##### **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:**

A review of five of five resident files identifies that resident’s interests are ascertained during the admission process as part of the lifestyle planning assessment. This information is used to inform activity planning so that resident strengths and skills are maintained. The service has 35 hours per week dedicated activities time.

Activities planning is undertaken on a monthly basis and each month a different ‘theme’ is identified and as many activities as possible are based around the theme. For example the July 2014 theme is the commonwealth games with shot-put, croquet, weight lifting and table games all being featured. There is also an outing planned to a local rugby club. The activities attendance records sighted identify a very good attendance rate at all activities.

The activities coordinators foster continued community activities identified by residents. Residents attend local community church groups, coffee clubs and card groups. A favourite trip for residents is a shopping trip to a local thrift shop where they purchase items of interest.

Weekly Catholic mass and a monthly interdenominational church service are offered on site. Residents are assisted to attend community church services if they choose.

Five of five resident interviews confirm they enjoy and participate in the activities of their choice.

##### **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:**

Five of five resident file reviews identify that a minimum of six monthly evaluations are undertaken and documented. Evaluation processes indicate the degree of achievement or response that was achieved for each resident to the interventions put in place.

If an intervention is not working then care planning identifies appropriate changes are made/sought with family/whanau and resident input. The service also undertakes a multidisciplinary review of residents annually where all aspects of the resident’s progress, care plan and needs are discussed and documented. This is confirmed by the residents and one family/whanau member who have been involved with the facility for over one year. (For one resident and one family/whanau member it has been less than one year).

During interview the GP stated that he is asked to undertake medical reviews if staff have any concern about a resident. This is confirmed in documentation sighted.

Five of five residents stated they feel that all their needs are met by the services offered.

##### **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:** FA

**Evidence:**

The service has a documented medicine management system in place which is implemented to ensure safe and appropriate prescribing, dispensing, administration, review, storage and disposal of medications. Policy identifies processes to undertake should a resident wish to self-administer medicines. Currently there are no residents who are self-administering medicines.

A review of ten of ten medication charts identifies that all medication is prescribed by a medical practitioner. The medication charts are pharmacy generated, signed by the GP and reviewed at least three monthly. Medicines arrive at the facility in medico blister packs for each individual resident. Non packaged medications are clearly labelled to identify which resident they are for. All medication is checked upon arrival at the facility for accuracy and signed to show this process has been undertaken. All staff who administer medication complete an annual competency which meets all best practice requirements including injectables. This is confirmed during the review of two caregivers, one RN and one EN staff file reviews.

Controlled drug process and standing orders are undertaken to comply with all legislative requirements. The medication round observed on the day of audit identifies that all administrative processes are undertaken to meet safe medication practices including the signing sheets when medication is given.

The pharmacy are involved in the reconciliation of medication upon delivery and during each residents annual multidisciplinary review process. All unused medicines are returned to the pharmacy in a timely manner. The medication fridge temperature is monitored regularly by the RN.

One standard with three areas (fridge monitoring, standing orders and three monthly GP reviews) identified for improvement in the previous audit are all fully attained.

##### **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:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a menu which has been reviewed and approved for aged care services by a registered dietitian on 7 January 2013. All food is ordered to match menu requirements and there is always at least three days food supply available.

There is evidence that if the service has any concerns related to nutrition the dietitian services are sought. Residents who have special nutritional needs and specific likes and dislikes have this clearly identified upon admission and identified in the kitchen. The service is able to cater for residents changing nutritional needs as confirmed during interview with the resident whose file was reviewed.

During interview with the kitchen manager and one kitchen assistant they confirm that any special dietary needs for residents can be catered for by the service. One example given relates to staff having specific education from the dietitian related to ensuring one resident who requires a gluten free diet has all their needs met. The staff verbalised an in-depth knowledge and understanding related to residents’ needs and likes including vegetarian diets, weight management and additional fluids such as jelly and soups.

The kitchen is well equipped and a cleaning regime is implemented to ensure the kitchen is kept clean and tidy at all times.

Regular fridge and freezer temperature recordings are undertaken to show that they meet safe food practice requirements. The two freezers located in the food storage area had high temperature readings. Upon investigation it is noted that the thermometers are incorrectly located in the freezers. They were repositioned and correct readings were made on the day of audit. During discussion with the catering manager it was agreed that additional education be given to kitchen staff to ensure they understand the need for accurate frozen food monitoring. All food is well labelled and dated to show expiry dates. The service has a rotation system in place to ensure older food is used first.

Interviews with five of five residents and two of two family/whanau members confirm the food meets their needs and likes.

##### **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:**

The sighted building warrant of fitness expires 4 March 2015. There have been no changes to the building that has affected the evacuation plan.

# 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:**

At the time of audit there are no residents with restraint or enabler use. The restraint minimisation policy documents that when enablers are used these will be voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining consumer independence and safety. Restraint minimisation education is part of the two yearly ongoing education schedule. The two of two caregivers interviewed demonstrate knowledge on the voluntary use of enablers.

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

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

**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:**

Surveillance data for infection is collected and recorded in accordance to the requirements for rest home level care as identified in policies and procedures. This includes urinary tract infections, skin and wound infections, gastro type infections, eye infections, lower respiratory tract infections and multi-resistant organisms.

All staff are responsible for the reporting of suspected infections to the infection control coordinator. The infection control coordinator (RN) along with the infection control committee (RN, laundry manager, kitchen manager and three caregivers) are responsible for ensuring appropriate action, notification and follow up is undertaken. During interview the infection control coordinator verbalised a clear understanding and knowledge of reporting and recording processes.

Monthly surveillance data is collected and collated by the infection control coordinator. Data is trended against previously collected data and used as an opportunity for improvement as required. The documented data sighted shows that the facility has a low infection rate with two months in 2014 having no recorded infections. All infections are notified to the GP and treated accordingly.

Infection control data and information is shared with staff and management as identified in meeting minutes sighted. Staff report they are notified of any infections at handover and family/whanau are contacted as required. This is confirmed during two of two family/whanau interviews.

##### **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.)*