# Agape Care Limited

## Current Status: 11 July 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Partial Provisional 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

Milton Court Rest Home is currently certified to provide rest home care for up to 26 residents and dementia level care for up to 10 residents. On the day of audit there were 13 residents in the rest home and 12 in the dementia unit (noting the extended dementia unit was already open for an increase in residents). A partial provisional audit was completed to review the services readiness to increase the size of the dementia unit from ten beds to 20 beds and reduce the rest home from 26 beds to 16 beds.

This audit identified that the renovated area attached to the existing dementia unit is appropriate for an additional ten dementia level beds. The new area has an additional lounge/ dining area that provides the additional space to allow residents to socialise outside of their rooms. There are policies and processes appropriate for providing rest home and dementia level care. The shortfalls identified at the previous certification around resident assessments, care planning interventions and medication documentation have been addressed. Environmental shortfalls around a designated smoking area and call bells in the rest home are now rectified. There is a further improvement required around call bells in the dementia unit.

# 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:** | Agape Care Limited |
| **Certificate name:** | Agape Care Limited |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Partial Provisional Audit | | | |
| **Premises audited:** | Milton Court Rest Home | | | |
| **Services audited:** | Rest home care (excluding dementia care); Dementia care | | | |
| **Dates of audit:** | **Start date:** | 11 July 2014 | **End date:** | 11 July 2014 |

**Proposed changes to current services (if any):**

Increase the size of the dementia unit from ten beds to twenty beds and reduce the rest home beds from 26 to 16

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 25 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 4 | **Hours off site** | 3 |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXXX |  |  | **Hours** | 1 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 4 | Total audit hours off site | 4 | Total audit hours | 8 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed |  | Number of staff interviewed | 4 | 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) | 20 | Number of relatives interviewed |  |
| Number of residents’ records reviewed using tracer methodology |  |  |  | Number of GPs interviewed |  |

## **Declaration**

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

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Not Applicable |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Wednesday, 13 August 2014

## **Executive Summary of Audit**

**General Overview**

Milton Court Rest Home is currently certified to provide rest home care for up to 26 residents and dementia level care for up to 10 residents. On the day of audit there were 13 residents in the rest home and 12 in the dementia unit (noting the extended dementia unit was already open for an increase in residents). A partial provisional audit was completed to review the services readiness to increase the size of the dementia unit from ten beds to 20 beds and reduce the rest home from 26 beds to 16 beds.

This audit identified that the renovated area attached to the existing dementia unit is appropriate for an additional ten dementia level beds. The new area has an additional lounge/ dining area that provides the additional space to allow residents to socialise outside of their rooms. There are policies and processes appropriate for providing rest home and dementia level care. The shortfalls identified at the previous certification around resident assessments, care planning interventions and medication documentation have been addressed. Environmental shortfalls around a designated smoking area and call bells in the rest home are now rectified. There is a further improvement required around call bells in the dementia unit.

**Outcome 1.2: Organisational Management**

Milton Court provides rest home and dementia care for up to 36 residents Occupancy on the day of the audit were 25 residents, 12 in the secure dementia unit and 13 in the rest home, The service has a documented business plan that has been reviewed for 2014. There is a documented quality plan which includes the planned increased dementia level beds and process for the planned changes.

The owner is the manager of the service, she is a non-practising registered nurse. Her responsibilities at the facility include maintaining certification, monitoring building compliance, contractual compliance, and environmental compliance.   
The full-time nurse manager is responsible for the day-to-day clinical and operational aspects of the service. She is a registered nurse (RN) with previous experience in mental health, aged care and rehabilitation. The nurse manager has completed leadership training.

Milton court has an implemented quality and risk management system.

**Outcome 1.3: Continuum of Service Delivery**

Five care plans reviewed, all five documented that resident assessments are in place with appropriate interventions in the care plans. The medication management system is appropriate and safe. The RN and senior care givers administer medications. Previous findings around resident assessments, care plan interventions and medication documentation have all been rectified.

**Outcome 1.4: Safe and Appropriate Environment**

The service has in place policies and procedures in place for the management of waste and hazardous. Protective equipment is available. Chemicals are stored safely throughout the facility. There is a current building warrant of fitness displayed in the rest home facility.   
There are no changes required to the fire evacuation schemes. Environmental equipment checks and hot water temperature monitoring is completed. All bedrooms are spacious and allow for the safe delivery of care. Residents are able to move around their rooms safely. There are emergency management policies and procedures in place and adequate civil defence supplies.

The new wing of ten beds in eight room (two double rooms) is appropriate for the care and support of dementia residents. The new wing is adjoined to the existing dementia wing and is secure, safe and warm.

Previous shortfalls around call bells in the rest home, and an appropriate smoking area have been rectified.

\

**Outcome 3: Infection Prevention and Control**

The infection control manual outlines a comprehensive range of policies, standards and guidelines and procedures includes (but not limited to); hand hygiene, standard precautions, surveillance, outbreak management, training and education of staff. The infection control programme in place is appropriate for the size of the service including hospital level care. There is an infection control co-ordinator with defined responsibilities for the management of infection control throughout the facility.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 18 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 1 | 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 | 31 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 62 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.4.7: Essential, Emergency, And Security Systems | Consumers receive an appropriate and timely response during emergency and security situations. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.7.5 | An appropriate 'call system' is available to summon assistance when required. | PA Low | There are no call bells in resident rooms in the dementia unit. | Review the lack of call bells in resident rooms to ensure staff and residents can access help in an emergency | 30 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **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:**

Milton Court provides rest home and dementia care for up to 36 residents Occupancy on the day of the audit were 25 residents, 12 in the secure dementia unit and 13 in the rest home.

The service has a documented business plan that has been reviewed for 2014. There is a documented quality plan which includes the planned increased dementia level beds and process for the planned changes.  
The owner is the manager of the service, she is a non-practising registered nurse. Her responsibilities at the facility include maintaining certification and monitoring building compliance, contractual compliance, and environmental compliance.   
The full-time nurse manager is responsible for the day-to-day clinical and operational aspects of the service. She is a registered nurse with previous experience in mental health, aged care and rehabilitation. The nurse manager has completed leadership training. The service has also recruited an additional registered nurse.   
  
A partial provisional audit was completed to review the service readiness to increase the secure dementia unit beds from 10 to 20 (and reduce rest home beds to 16).

This audit identified that the newly refurbished and renovated dementia wing is suitable for the provision of dementia care. The new wing has dining and lounge areas and existing policies and procedures are appropriate for dementia care   
The service is a member of CANZ (Care Association New Zealand). Training records for staff evidence that dementia appropriate training is provided and all training exceeds hours per annum. Much of the service training is provided by the DHB nurse specialist team.

##### **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 1.2.2: Service Management **(**HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

**Attainment and Risk:** FA

**Evidence:**

In the absence of the nurse manager, the registered nurse oversees the clinical management of the facility. The service has appropriate policies and procedures to guide practice that are appropriate for rest home and dementia level care.

##### **Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)**

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

**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:**

All new staff undertake an orientation on commencing that provides them with relevant information for safe work practice. These are documented on all five individual staff files reviewed.

There is a comprehensive mandatory education programme with in-services held each month. The programme includes management of challenging behaviour and delirium. The range of topics provided meet ARC contractual requirements and exceeds eight hours per year. External education is provided through the Waitemata District Health Board (WDHB). The WDHB Gerontology Nurse Specialist, the WDHB Wound Care Nurse Specialist and the WDHB Dementia Care Specialist provide specialist training and consultation. The owner and nurse manager both attend aged care conferences.

Copies of practising certificates were sighted for the both registered nurses (registered nurse and nurse manager) and the GP.   
Five staff files were randomly selected for review (the house keeper, the cook and three caregivers). All document annual appraisals.   
There are 14 caregivers who work in the dementia unit. All staff who have been employed longer than six months have completed the dementia unit standards. Seven staff who have been employed less than six months have commenced the unit standards (including the registered nurse).

Care givers are enrolled onto career force with three completed level three and three in the process of completing level three.

The service ensures a first aider on every shift by training all staff in first aid.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service has a nurse manager who works Monday to Friday (and on call) and an RN who works 32 hours a week Monday to Friday.

The proposed roster for the reconfiguration of 20 dementia beds and 16 rest home will be;

For the dementia unit;

For the AM; two caregivers.

For the PM; two caregivers

For the night shift; two caregivers.

Housekeeping, laundry and activity staff hours will remain the same.

The rest home will reduce staff to one caregiver each shift.

The service has staffing in place to accommodate this roster.

##### **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:** FA

**Evidence:**

The previous audit evidenced assessments and care plans are not always completed by the RN. This audit reviewed five resident files, three rest home and two dementia. All assessments and all care plans had been completed by the RN. The RN states she has reviewed all resident files and updated as needed since the previous audit.

##### **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.)*

#### Standard 1.3.4: Assessment **(**HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

**Attainment and Risk:** FA

**Evidence:**

The previous audit evidenced that pain assessments are not in place for residents with identified pain and challenging behaviour assessments are not in place for residents in the dementia unit. This audit reviewed five resident files, three rest home and two dementia. Of the two dementia unit residents files reviewed, both have identified challenging behaviour. Both residents have behaviour monitoring forms and the care plans have in-depth interventions for behaviour that challenge, including triggers and interventions for behaviour.

One rest home file was reviewed specifically for pain assessments and interventions. This resident has pain assessments in place, assessment has been reviewed monthly. The care plan documents pain interventions.

##### **Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)**

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

**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 1.3.5: Planning **(**HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

**Attainment and Risk:** FA

**Evidence:**

The previous audit identified that care plans did not identify specific needs for a range of resident files reviewed. This audit reviewed five resident files (three rest home and two dementia). The RN on interview stated that resident files have all been reviewed and updated to ensure that resident needs are included in care plans with interventions as needed. The five files reviewed all had comprehensive resident interventions in place.

The dementia resident files (two) included behaviour management including recognition of behaviours that are considered ‘normal’ and challenging. There was a seizure recognition and management plan in place for one resident and a STCP post fall which included pain management for another resident.

Rest home resident files (three) included one resident with pain who has monthly pain re-assessments and care plan interventions documented, a diabetic resident has this documented well in the care plan and one resident with reported chest pain and a STCP which has recently been reviewed and discontinued.

##### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

**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:**

Interview with the RN and review of progress notes in five files evidences that she reviews all progress notes daily, and ensures that any RN follow up needed takes place and is documented.

Assessments including continence, and pain with associated care plan interventions are in place on the five files reviewed.

The service has three residents with wounds (all skin tears in the dementia unit). There are wound assessments, wound care management plans and wound evaluations in place for all three wounds.

##### **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 1.3.12: 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 medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: Safe Management of Medicines, A Guide for Managers of Old People’s Homes and Residential Care Facilities and the Ministry of Health, Medicines Care Guide for Residential Aged Care 2011.

The service will continue the current medication process of keeping main medication room is located within the rest home wing and a locked medication trolley in the dementia wing dining area.

Milton House continues to use blister medication packs. Medications are checked on arrival by afternoon staff.

The nurse manager, /RN and caregivers complete annual medication and controlled drug competencies annually. This includes a questionnaire and practical audit of medication administration.

Ten resident medication charts were reviewed and all are identified with photographs and were current. All ten signing sheets reviewed were correct and complete. Allergies and intolerances are recorded on the drug chart. . PRN medications are dated and timed on administration. There are no gaps in the signing sheets. Medication charts (have been reviewed by the GP at least three monthly. All ten medication charts included an indication for use of prn medications charted this is an improvement since the previous audit

Controlled drugs are stored in a locked safe and a review of the controlled drug register shows all controlled drugs are checked by two people. The controlled drug pharmacy signing sheet is signed by two medication competent persons. Weekly controlled drug stock takes have been completed, this is an improvement since the previous audit. Controlled drugs will continue to be stored and administered from this secure location in the main rest home area medication room.

D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the resident three monthly and the medication chart was reviewed and signed.

Weekly controlled drug physical stocktakes undertaken by a RN and one other medication competent person. Expiry dates are checked of all stock.

Fridge temperatures are monitored. Standing orders are not used.

##### **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:**

All meals are prepared on site the main kitchen overlooks the new dementia wing with a secure kitchen bench allowing residents to view the kitchen area.

The service employs two cooks, both of whom have food handling certificates. The cook is aware of resident likes, dislikes and any special dietary requirements. Resident dietary profiles are received for new admissions and there is evidence six monthly reviews.

The kitchen was observed to be well maintained and clean, Meals are observed to be well presented. Nutritious snacks such as sandwiches, yoghurts and desserts are available after hours for dementia and rest home residents.

A copy of resident’s nutritional profiles/ likes and dislikes are sent to the main kitchen and also a copy is kept in the kitchen serveries on site. The kitchen has a comprehensive system whereby they are kept current with changing needs of the residents.

Residents are also given a choice. There is evidence of modified diets being provided e.g. Diabetic menu and further nutritional supplements.

Fridge, food and freezer temperatures are monitored and documented. Food in the chiller and freezer was covered and dated.

Staff were observed wearing correct protective clothing and safe footwear.

##### **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 1.4.1: Management Of Waste And Hazardous Substances **(**HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures are in place and implemented for the safe and appropriate storage and disposal of waste and hazardous substances. The service has an emergency plan for the management of waste and hazard incidents or accidents. Sharps are disposed of into an approved container. There is an accident/incident system for investigating and recording all incidents. All completed forms are reviewed by the manager/owner. Staff are aware of their responsibilities relating to reporting and recording any incidents as confirmed on interview with four caregivers.   
On audit day staff are observed wearing appropriate protective equipment including aprons and gloves and goggles. Chemicals are stored in locked staff only designated areas. Chemical bottles sighted have correct manufacturer labels. Safety Data Sheets (MSDS) are available for all chemicals used and outline appropriate first aid procedures. Training in the management of waste and hazardous substance and chemical safety occurs at orientation and on an on-going basis. Cleaners have attended chemical training.   
General waste is removed by waste management contractor. Recycling of tins, plastics, newspapers and cardboard occur.

In the new wing it was observed that all chemicals were safely stored and residents have no access to areas such as the kitchen and laundry

##### **Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)**

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

**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 1.4.1.6 (HDS(C)S.2008:1.4.1.6)**

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used 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.)*

#### 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 new wing has ten additional dementia beds and is adjoining the ‘old’ dementia unit. The two units have door between them which is kept open during the day. The new wing has a separate lounge and dining area. The lounge/ dining area has a fish tank, lounge chairs dining tables and is appropriate for residents at dementia level care.  
  
There are eight resident rooms in the new wing, two of which are double rooms. Three of the rooms have an en-suite. There is also a communal shower and a toilet in the new wing. Residents also have access to the two showers and two toilets in the ‘old’ wing.

All resident bedrooms have hand basins. Monthly hot water temperature monitoring in resident rooms is stable between 43-45 degrees Celsius.   
There are handrails in all hallways that enable residents to move around the facility safely. Doorways are kept clear of hazards.

There is a maintenance person 15 hours a week. A maintenance record and request form is used for maintenance requests. Corrective actions are sighted. There is a monthly safety checklist that includes checks on carpets, handrails, ramps, hallways and floors. There are six monthly equipment checks. Electrical equipment has been tested and tagged March 2014. The stand on scales and clinical equipment has been checked January 2014. On-going maintenance includes painting, gardens and grounds.  
There are security gates at the entrance of the facility. Entry is by call bell. The keypad number is displayed for visitors and residents to freely exit the facility.   
There are safe outside areas that are easy to access for residents and family/whanau members. These include outdoor shade, tables and chairs. There is a safe garden and grounds area for dementia residents.

The service has a current BWoF displayed expiring June 2015.  
  
D15.3d the lounge areas are designed so that space and seating arrangements provide for individual and group activities.   
ARC D15.3; The following equipment is available, pressure relieving resources, transfer belts, mobility aids, wheelchairs, weigh scales, gloves, aprons and masks

The designated smoking area if far enough away to prevent other residents being affected by smoke, this is an improvement on the previous audit.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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 1.4.3: Toilet, Shower, And Bathing Facilities **(**HDS(C)S.2008:1.4.3)

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

Three rooms have an en suite bathroom and toilet. The new wing has a communal toilet and a bathroom. Residents also have access to the two bathrooms and two toilets in the ‘old wing’.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.4: Personal Space/Bed Areas **(**HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

**Attainment and Risk:** FA

**Evidence:**

There is adequate personal space is provided in all bedrooms to allow residents and staff to move around within the room safely. The two double bedrooms in the new wing have privacy screens to use as needed. All floors are vinyl floors. Residents have access to the lounge /dining room in the new wing and the lounge/dining room in the ‘old’ wing. Activities can take place in either lounge.

##### **Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)**

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

**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 1.4.5: Communal Areas For Entertainment, Recreation, And Dining **(**HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

**Attainment and Risk:** FA

**Evidence:**

The new wing has its own lounge and dining area. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. The arrangement of furniture and seating allows residents to move freely in the lounge and dining room areas.

Sunny outdoor areas provide as an alternative recreational area. Residents can use their bedrooms or the outdoor areas, if they require privacy at any time. There is an open plan dining, lounge and recreational area in ‘old’ wing also available to all residents. There is sufficient seating and space to accommodate the residents.

##### **Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)**

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to 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.)*

#### 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:**

There is a laundry worker from 7-9am daily to commence the sorting and washing of linen and personal washing. Laundry duties are then shared by the caregivers on duty. The laundry is well equipped and has a defined dirty/clean area and sluice tub. There are designated locked cleaning cupboards. There is a chemical dispensing unit for the refill of chemical bottles. Cleaners are employed Monday to Sunday in the mornings to carry out the cleaning duties. Staff are observed wearing correct personal protective equipment. Safety data sheets are available. Chemical bottles are labelled correctly. The laundry and cleaning service are regular agenda items at staff meetings.

##### **Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)**

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

**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 1.4.6.3 (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.)*

#### Standard 1.4.7: Essential, Emergency, And Security Systems **(**HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

**Attainment and Risk:** PA Low

**Evidence:**

Emergency and disaster policies and procedures are in place. The New Zealand Fire Service approved the fire evacuation plan on 21 June 1996. A fire drill takes place six-monthly with the most recent drill occurring in April 2014. The orientation programme includes fire and security training.

All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ. A back up three- hour battery for emergency lighting is in place.   
The system that was previously in place has been decommissioned.

The rest home has call bells in all resident rooms and communal areas.

The ‘old’ and ‘new’ dementia unit wings have call bells in the corridors, communal areas and toilets. These are linked to display screens and staff pagers. There are no call bells in resident rooms in the dementia unit and this should be reviewed.  
This is a secure facility, surrounded by a gate with key pad access. External lighting is adequate for safety and security.

##### **Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)**

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

**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 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation 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.)*

##### **Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

Alternative energy and utility sources are available in the event of the main supplies failing.

**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 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

An appropriate 'call system' is available to summon assistance when required.

**Attainment and Risk:** PA Low

**Evidence:**

The ‘old’ and ‘new’ dementia unit wings have call bells in the corridors, communal areas and toilets. These are linked to display screens and staff pagers. There are no call bells in resident rooms in the dementia unit.

**Finding:**

There are no call bells in resident rooms in the dementia unit.

**Corrective Action:**

Review the lack of call bells in resident rooms to ensure staff and residents can access help in an emergency

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

##### **Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the 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.)*

#### Standard 1.4.8: Natural Light, Ventilation, And Heating **(**HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

**Attainment and Risk:** FA

**Evidence:**

All resident rooms are heated with panel heaters, the new wing was warm and ventilated on the day of audit. Documentation and visual inspection evidences that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature

There is a designated external smoking area that does not affect any resident with second hand smoke.

##### **Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)**

Areas used by consumers and service providers are ventilated and heated appropriately.

**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 1.4.8.2 (HDS(C)S.2008:1.4.8.2)**

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. There are infection control policy and procedures developed by an external consultant. There is an established and implemented infection control programme. The 2013 infection control programme has been reviewed. The 2014 draft infection control programme is linked to the annual quality risk plan.

The nurse manager is the Infection Control Coordinator. The role and responsibility of the infection control co-ordinator is defined within the nurse manager job description.   
The infection co-ordinator reports to the management meeting with representatives of owners, clinical, cleaning and food services staff. Infection control is a set agenda item at staff meetings monthly. Minutes are available for staff.  
There have been no outbreaks. Hand sanitizers are available at all entrances. Residents are strongly encouraged to have annual influenza vaccinations.

##### **Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)**

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

##### **Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)**

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

**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:** Not Audited

**Evidence:**

**Finding:**

**Corrective Action:**

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