

Current Status: 25 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

This surveillance audit was undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Tarahill provides residential rest home level care for up to nineteen residents with eighteen residents present on the day of audit.

There are two owners who reside next door, with one identified as the Nurse Manager and the other who supports with maintenance. Staffing is appropriate to support the needs of residents requiring rest home care; and there is a quality and risk management programme that is well documented and implemented, with evidence of improvements in the service.

The three improvements required at the previous certification audit around consent, risk assessment and documentation of medication administration are fully addressed.

There are no improvements identified as being required at this audit.

Audit Summary as at 25 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

Indicator	Description	Definition
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

Consumer Rights as at 25 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 25 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 25 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 25 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 25 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 25 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:	G A & H J Lydford		
Certificate name:	G A & H J Lydford		
Designated Auditing Agency:	Health Audit (NZ) Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Tarahill Resthome		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	Start date: 25 July 2014	End date: 25 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:	18
-----------------------------------------------------------------------------------------------------	----

Audit Team

Lead Auditor	XXXXXXXX	Hours on site	7.5	Hours off site	4
---------------------	----------	----------------------	-----	-----------------------	---

Other Auditors	XXXXXXXX	Total hours on site	7.5	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	5	Number of managers interviewed	1
Number of residents' records reviewed	6	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	16	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	0

Declaration

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

I confirm that:

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

Dated Tuesday, 29 July 2014

Executive Summary of Audit

General Overview

This surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract for Tarahill. Tarahill provided residential rest home level care for up to nineteen residents with eighteen residents requiring rest home level care.

There were two owners who reside next door with one identified as the nurse/manager and the other who supported with maintenance. Staffing is appropriate to support the needs of residents requiring rest home care and there is a quality and risk management programme that is well documented and implemented with evidence of improvements in the service.

The three improvements required at the certification audit around consent, risk assessment and documentation of medication administration were fully addressed.

There were no improvements identified as being required at this audit.

Outcome 1.1: Consumer Rights

Written consent is obtained during the admission process with regard to residents` record management and sharing of residents` information with other health providers. An area of required improvement from the previous audit in relation to transportation consent is fully attained. The `Tarahill Rest Home Outing and Indemnity Consent` form has been developed and implemented.

Outcome 1.2: Organisational Management

Tarahill has a documented quality and risk management system that supports the provision of clinical care and support. There is monitoring of service delivery through review of incidents, accidents, infections, complaints and through feedback received from family members and residents. There is a staff meeting and a resident meeting monthly to communicate all issues and for discussion to occur.

Staffing levels are adequate with the nurse/manager providing leadership and clinical oversight at all times. There is another registered nurse who provides hands on support four hours a week and is rostered on call every second fortnight.

Outcome 1.3: Continuum of Service Delivery

The service has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring rest home level care. The nurse manager and registered nurse oversee the care and management of all residents along with a team of caregivers. Continuity of care is encouraged. All residents are assessed on admission and assessment details are retained in the individual resident`s records. The absence of a skin integrity assessment was identified as an area of required improvement in the previous audit and this has been fully attained with the development and implementation of a skin integrity assessment evidenced and completed in all six resident files reviewed.

The residents' care plans are well documented and clearly identify the needs, outcomes and/or goals and these are reviewed six monthly or more often as required. The resident and family are involved in the care planning and review process.

The activities available are appropriate for residents requiring rest home level of care. An experienced activities co-ordinator develops and implements the activities programme.

Medication management systems comply with current legislation and the staff involved in medication management have completed medication competencies annually. The nurse manager is responsible for the medication management and works alongside a contracted pharmacist and the general practitioners.

Food is prepared on site and overseen by two cooks. The menu plans have been reviewed by a dietitian. Visual inspection of the kitchen evidences compliance with current legislation and guidelines. The two cooks have completed food safety training. Meals are provided at appropriate times of the day.

Outcome 1.4: Safe and Appropriate Environment

There is a current building warrant of fitness in place. There are safe and accessible indoor and outdoor areas for residents with a preventative and reactive maintenance programme in place.

Outcome 2: Restraint Minimisation and Safe Practice

The service has a commitment to a policy and philosophy of 'non-restraint' and appropriate use of restraint/enablers, should these be required. Clear definitions in the policies reviewed ensure staff understand the implications of restraint and enabler use. Restraint and enablers are only used as a last resort. There are no enablers in use.

Outcome 3: Infection Prevention and Control

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

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	18	0	0	0	0	0
Criteria	0	43	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	32
Criteria	0	0	0	0	0	0	0	58

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:

Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available.

Family are informed if the resident has an incident, accident, has a change in health or a change in needs, evidenced in 10 of 10 completed accident/incident forms and in the resident files in the progress notes/registered nurse notes as sighted in three of three files reviewed.

Interviews with three family members confirm they are kept informed.

Family interviewed confirm that they are treated as 'family of Tarahill Rest Home (Tarahill)' and state that they can talk with the nurse/manager at any time. They also state that staff are approachable and communicate well.

Interpreter services are available when required from the District Health Board. There are no residents currently requiring interpreting services.

The information pack is available in large print and advised that this can be read to residents.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Written consent processes and advanced directives are fully described in policy. The policy sighted relates to informed choice and consent and the information is compliant with the Code requirements. The service has specific advanced directive documentation which identifies resident's advanced directives prior to admission and other documentation which identifies resident and/or family whanau involvement in this process.

Enduring power of attorney verification if available is retained in the individual resident's file. The senior caregiver/activities co-ordinator at interview has a good understanding of informed choice and consent. Written consent is obtained during the admission process with regard to residents record management and sharing of residents' information with other health providers (for example, pharmacist, geriatrician, GP service obligations and for the referral process). An area of required improvement from the previous audit in relation to transportation consent is fully attained. The 'Tarahill Rest Home Outing and Indemnity Consent' form has been developed and implemented.

The District Health Board contract requirements are met.

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

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 organisation's complaints policy and procedures is in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes time-frames for responding to a complaint. Complaint's forms are available at the entrance of the rest home.

A complaints register is in place and the register includes the date the complaint was received; the source of the complaint; the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint's folder.

One complaint is lodged in 2014 and one in 2013. A complaint selected for review indicates that there is documented evidence of time-frames being met for responding to these complaints with documentation indicating that the complainants are happy with the outcome.

Five of five residents and three of three family interviewed confirm that they would feel comfortable complaining.

The nurse/manager states that there have been no complaints with the Health and Disability Commission since the last audit or with other authorities.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

There are two owners who live next door to the facility. One is the nurse manager and has been in the position for 18 years (enrolled and psychiatric nurse). The other owner takes on the role of maintenance for the facility and the owners have owned the facility for five years. Both are on site during the weekdays and weekends and are supported by the registered nurse who provides four hours a week support and the activities coordinator who is identified as the second in charge. The nurse manager has at least eight hours training relevant to the role, annually.

There is a philosophy and goals documented with this displayed in the foyer.

The facility can provide care for up to 19 residents requiring rest home level of care. There are currently 18 residents in the service including one resident requiring respite services.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Tarahill has a quality and risk management framework that is documented to guide practice. There are plans with annual reviews to guide operational management and service delivery including the following: management plan 2014, quality improvement and risk management plan 2013/2014, health and safety management review 2013 (completed in September 2013), safe medications review (completed 2014), restraint review (completed May 2014), service delivery review (completed June 2014).

The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies having been reviewed last in 2014 with the registered nurse and nurse manager involved in the review. Policies are readily available to staff in hard copy in the office. Staff interviewed state that they read any new or revised policies.

All staff interviewed including two of two caregivers, the activities coordinator and the cook report they are kept informed of quality improvements.

The organisation has a comprehensive risk management programme in place. There is a hazard management programme documented 2013-14 with a hazard register for each part of the service. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated. Health and safety policies and procedures are in place for the service.

There is an annual resident/family satisfaction survey and results documented in June 2014 from the most recent survey indicate that residents and family are very happy with the service and environment with no suggestions for improvement. Service delivery is monitored through review of complaints, review of incidents and accidents with monthly analysis of data, surveillance of infections, implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues documented when these are identified. There is evidence of collection, collation, analysis of data, and identification of trends.

There are monthly staff meetings held that include all aspects of the quality programme. There are also monthly resident meetings with family able to attend if needed.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The nurse/manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There are no times since the last audit when authorities have had to be notified. There have been no outbreaks since the last audit.

The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process, evidenced in interviews with staff, the nurse/ manager and activities coordinator.

Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to documenting all untoward events.

Ten incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event.

Information gathered is regularly shared at the monthly staff meeting. Analysis of incidents and accidents occurs monthly with trends analysed and in each resident file, there is an annual graph kept of individual incidents that have occurred.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The registered nurse and the nurse/manager hold current annual practising certificates. Visiting practitioner's practising certificates include the general practitioner, dietitian, podiatrist and physiotherapist.

Five of five staff files randomly selected for audit include appointment documentation on file including signed contracts, applications, signed privacy and confidentiality form and evidence of orientation including a buddy checklist. There is an annual appraisal process in place with all staff having a current performance appraisal. First aid certificates are held in staff files along with other training records.

All staff undergo a comprehensive orientation programme (evidenced in all staff files) that meets the educational requirements of the Aged Residential Care (ARC) contract. Caregivers are paired with a senior caregiver for shifts until they demonstrate competency.

Annual medication competencies are completed for all caregivers and the registered nurses including the nurse/manager who administer medicines to residents.

The caregivers state that they value the training. Education and training hours exceed eight hours a year. There are folders of attendance records and training.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: 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 policy around staffing which is the foundation for work force planning. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy. The rosters for an occupancy of 18 residents are as follows:

There are four caregivers in the morning, one of whom takes the activity coordinator role until 1pm or 3pm depending on needs of residents with another who works a split shift, coming back over the tea period to support residents. There is another caregiver in the afternoon who works a full shift and hands over to a caregiver who works overnight. The nurse manager is also the owner and lives next door. Staff confirm that the nurse manager is available at any time and responds immediately if rung.

There are 16 staff including the nurse manager, activities coordinator, two cooks, one cleaner and 11 caregivers. The other owner completes maintenance.

Residents and families interviewed confirm staffing is more than adequate to meet the residents' needs and all five residents and three family members praised the staff and nurse manager as 'having a heart', 'family focused', 'providing a truly resident focused service'.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA

Evidence:

Service delivery documentation is overseen by the nurse manager at Tarahill Rest Home. Documentation is part of the audit process and reviewed at regular intervals to ensure documentation is completed within required time-frames. In the six individual resident files reviewed there is evidence of initial assessments and care plans being completed appropriately to meet the obligations of the district health board contract.

The clinical risk tools used include falls risk, pressure area (Braden Scale), skin integrity, wound care, continence, pain and mini nutritional risk assessments. An area of required improvement from the previous audit in relation to no falls risk or skin integrity assessments being performed has been fully attained with the development and implementation of both of these assessments.

The nurse manager has completed the training for InterRAI which is the long term care facilities (LTCF) assessment tool. InterRAI has not currently been implemented for this service. The care plan template is personalised, reviewed by the nurse manager and/or the registered nurse within required timeframes.

The nurse manager reports there is a process for annual multidisciplinary resident reviews or earlier review if required. There are three monthly reviews with the GP and clinical staff. Family/whanau are notified of any changes. There is evidence in the six resident files reviewed that family/whanau are involved in all areas of care management. The rest home has various GPs who visit from one practice regularly and when required. Residents that are able are taken to the medical practice by staff as required. There is always a general practitioner on call from the medical practice 24 hours a day, seven days a week (24/7) for all residents. No GP was available during the audit in person or by phone.

The nurse manager interviewed reports regular contact with the community nurse practitioner occurs by phone or arrangements can be made for visits to this rest home to assess a resident or for advice such as for wound care management.

The five residents interviewed are very positive about the staff, GP and all aspects of care. The two senior caregivers and one activities co-ordinator/caregiver report they are kept up to date with all clinical changes.

The District Health Board contract requirements are met.

Tracer Methodology Rest Home Level Care:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (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:

Six resident records reviewed evidence that the goals of residents are realistic and are identified through the assessment process on admission to this service. Additional recognised assessments are used as required for individual residents such as pressure area risk (Braden Scale), nutritional status, falls, gait, pain management, wound-care and continence assessments. An area of required improvement from the previous audit has been addressed with the development and implementation of a skin integrity assessment which is now completed on all residents as part of the admission assessment process. This assessment is evident in the six residents' files reviewed. These assessments are used as the basis of the care planning.

The District Health Board requirements are met.

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 1.3.6: 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 six resident`s files reviewed there is evidence of the identified needs of residents being assessed in line with their desired outcomes. This includes remaining as independent as possible and being included in all care decisions. The five residents report on interview that they are involved in their care and feel that they are treated as an individual. Three family available for interview during the audit confirmed their input and participation was welcomed by management and staff.

The six staff report on interview that they know the residents individually, as this is a small facility and they ensure they work within the resident`s care plans, which are based on the residents` assessed needs. The care plans are reviewed six monthly or more often if required and the interventions are updated if needed to meet the goals set.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The experienced activities co-ordinator facilitates the activities programme for all residents in the rest home. At interview the co-ordinator reports that she will be completing the New Zealand Society of Diversional Therapist training in approximately three to six months. The activities co-ordinator discussed the role which includes assessing each individual resident on admission and from the information gained develops an individual plan for each resident. The assessment and plan was evident in the six files reviewed. From the information of past history, likes and dislikes, special interests the weekly programme is developed. The programme reviewed is implemented ensuring the strengths, skills and interests of residents are maintained.

Outings in the community are encouraged as is family participation. Two weekly outings to local church groups for coffee mornings are enjoyed by the residents.

Five residents interviewed report they are happy with the activities provided and staff report they are encouraged to participate in the programme and enjoy the activity involvement. An example of this is the mid-year Christmas function held in June 2014.

The District Health Board contract requirements are met.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA

Evidence:

Long term care plans are reviewed six monthly or earlier as required. Evidence of this was sighted in the six files reviewed. Progress notes are signed each duty by the caregivers and regularly updated by the registered nurse or the nurse manager. Multidisciplinary input is considered for all residents for the annual reviews. Reviews occur earlier if there is a change in the resident's status. Interventions are changed if required to ensure all needs and goals set can be effectively met. All evaluations are recorded, dated and signed by the registered nurse or nurse manager undertaking the review. Short term care plans are utilised for wound care, infections, changes in mobility and changes in food and fluid intake, and/or skin care and pressure area risk. These processes are clearly documented on the short term care plan, medical and nursing assessments and in the residents' progress notes. This is evidenced in one resident's file in relation to two separate wound care assessments and consultation performed by the nurse practitioner.

In the six files reviewed evidence is seen of documentation if an event occurs that is different from expected. The GP is contacted and the resident/family/whanau communication and education provided is recorded in the progress records. The staff interviewed understand documentation requirements and report they are well informed at handover of shifts if any care changes are required for residents.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is a detailed medication policy that is reflective of current safe practice guidelines. The policy identifies that staff who administer medicines must be competent. There are nine caregivers who administer medications and all have completed medication competencies for 2014. The nurse manager maintains up to date records of training. The allocated time-frame for competencies to be completed is documented as September 2014. Procedures comply with legislative requirements. The senior caregiver is observed giving out the lunchtime medication and complies with regulation requirements. An apron was worn to identify the caregiver completing the round so as not to be disturbed at this time. The robotic system is the system of choice and this is working effectively. There is one medication trolley for this facility and this is appropriate for the size and nature of the service.

The controlled drugs are checked weekly every Tuesday by two staff one of whom is a registered nurse. Six monthly reviews by the contracted pharmacist occurs. The nurse manager monitors the medication fridge temperature and ensures the temperature is within the normal range required for safety purposes. Storage is appropriate. No residents are self-medicating medication.

Ten medication records reviewed evidence photo identification on each resident record sheet. Any allergies or sensitivities are documented in red on the medical notes and the resident's medication record. All medications are prescribed individually and signed and dated by the GP. This is an area of required improvement from the previous audit that is now met and is clearly evidenced in the twelve medication records reviewed that transcribing does not occur in accordance with legislative requirements. The pharmacist stamps each individual medication record when the pack is completed. The registered nurse checks the medication packs when received from the pharmacy.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: 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 rest home uses the summer/winter seasonal menu which is due for a dietitian review this year. Nutritional guidelines for older people are available and considered when the menu plans are developed and reviewed by the dietitian.

The evening meal is served as the main meal and residents at interview preferred this option.

An individual dietary assessment (nutritional status) is completed on admission for all residents which identifies individual needs and preferences. Morning and afternoon teas are prepared in the kitchen and snacks are available over twenty four hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the resident's GP and notifying the kitchen of extra dietary requirements. The service is managed by two cooks over seven days. Special diets can be arranged, for example puree, fortified fluids, vegetarian diets or gluten free, or any other types of food requirements can be effectively met.

Evidence is sighted of meal planning, cleaning routines and audit requirements being completed. All staff have completed relevant food safety certificates, infection control and first aid certificates and each staff member has their own record maintained by the nurse manager. The cook reports on interview that both cooks are supported by management with the ordering and purchasing of food supplies and understands the individual requirements of the residents. Foods are stored appropriately, all above floor level and the fridges and freezers are monitored on a daily basis.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA

Evidence:

A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date 17 June 2015). There have been no building modifications since the last audit.

There is a planned maintenance schedule implemented with the owners completing maintenance as required.

The lounge area is designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounges on the day of the audit. The areas are suitable for residents with mobility aids.

The service is located in a rural area with pathways around grassed areas. There is a large driveway and concreted parking area outside with seating available for residents.

The District Health Board contract requirements are met.

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

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

Policies and procedures on restraint minimisation and use of enablers is documented and links specifically with the policy for managing challenging behaviour. These are accessible to guide staff actions related to restraint and enabler use.

There is no evidence of restraint or enablers being in use at this facility.

The service has a commitment to a 'Non-restraint' policy, philosophy and appropriate use of enablers/restraint. Enablers are only used for safety reasons. Staff interviewed understand that the use of enablers is to be a voluntary and the least restrictive to meet the needs of residents with the intention and/or maintaining resident independence. Training records evidence training occurs at orientation and is ongoing. The nurse manager is the restraint co-ordinator.

The District Health Board contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Surveillance results are used to identify infections or events and are appropriate for the size and nature of this service. Analysis includes identification of infections that are affecting one or multiple residents, what organisms are identified and the possible causes. The resident surveillance record records the date, infection site, antibiotic/treatment, outcome and the signature of the staff member reporting the infection.

The infection data is evaluated and trends analysed. Each resident has their own graph and any incidences are recorded monthly and copy is retained in their individual files. All surveillance data is reported at the staff meetings and evidence of this is seen in the minutes. The three caregivers interviewed report they receive annual infection control education and understand the need to report infections.

The District Health Board contract requirements are met.

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.)*