

# Lifecare Funds Limited

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Current Status: 24 June 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

## General overview

Kolmar Lodge Rest Home is owned by Lifecare Funds Limited who own two other homes in the Auckland region. Kolmar Lodge provides care for up to 26 rest home residents and on the day of audit there are 19 residents. Kolmar Lodge is overseen by a duty manager who has worked at the facility for seven years and in her current role for four years. Clinical support is provided by a charge nurse (registered nurse). There are developed systems to provide quality care for residents. There is an orientation and training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. The shortfalls from the previous certification audit around informed consent, documentation, medication management and the external environment have been met. This audit identified one area of improvement around care planning.

## Audit Summary as at 24 June 2014

Standards have been assessed and summarised below:

### Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

### Consumer Rights as at 24 June 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 24 June 2014

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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### Continuum of Service Delivery as at 24 June 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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### Safe and Appropriate Environment as at 24 June 2014

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### Restraint Minimisation and Safe Practice as at 24 June 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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### Infection Prevention and Control as at 24 June 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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# HealthCERT Aged Residential Care Audit Report (version 4.2)

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## 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

<b>Legal entity name:</b>	Lifecare Funds Limited
<b>Certificate name:</b>	Lifecare Funds Limited
<b>Designated Auditing Agency:</b>	Health and Disability Auditing New Zealand Limited
<b>Types of audit:</b>	Surveillance Audit
<b>Premises audited:</b>	Kolmar Lodge Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	<b>Start date:</b> 24 June 2014 <b>End date:</b> 25 June 2014

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

<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	19
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## Audit Team

<b>Lead Auditor</b>	XXXXXXXX	<b>Hours on site</b>	12	<b>Hours off site</b>	8
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<b>Other Auditors</b>		<b>Total hours on site</b>	0	<b>Total hours off site</b>	
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXXXX			<b>Hours</b>	2

## Sample Totals

Total audit hours on site	12	Total audit hours off site	10	Total audit hours	22
Number of residents interviewed	4	Number of staff interviewed	4	Number of managers interviewed	2
Number of residents' records reviewed	5	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	10	Total number of staff (headcount)	18	Number of relatives interviewed	1
Number of residents' records reviewed using tracer methodology	1			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	Yes
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 Friday, 25 July 2014

## Executive Summary of Audit

### General Overview

Kolmar Lodge Rest Home is owned by Lifecare Funds Limited who own two other homes in the Auckland region. Kolmar Lodge provides care for up to 26 rest home residents and on the day of audit there are 19 residents. Kolmar Lodge is overseen by a duty manager who has worked at the facility for seven years and in her current role for four years. Clinical support is provided by a charge nurse (registered nurse). There are developed systems to provide quality care for residents. There is an orientation and training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. The shortfalls from the previous certification audit around informed consent, documentation, medication management and the external environment have been met. This audit identified one area of improvement around care planning.

### Outcome 1.1: Consumer Rights

There is an open disclosure policy. Interviews with residents and one relative confirm family are kept informed of their family member's current health status including any adverse events. A complaints process is implemented.

### Outcome 1.2: Organisational Management

The service continues to implement a quality and risk management system that includes management of incidents, complaints, infection control surveillance data. There is an implemented internal audit programme to monitor outcomes. There is an appropriate manager who provides guidance for the service and is supported by a charge nurse and experienced care staff. The charge nurse provides clinical oversight during weekdays and there is registered nurse support available afterhours. There is an implemented in-service training schedule, the service has sufficient staff allocated to enable the delivery of care.

### Outcome 1.3: Continuum of Service Delivery

The sample of resident files reviewed demonstrate systems to assess, plan and evaluate care needs of the residents. Care plans demonstrate service integration. Care plans are reviewed six monthly. Resident files include notes by the GP and allied health professionals. There is an improvement required around care planning documentation. Medical policies and procedures are in place to guide practice. Education and medicines competencies are completed by staff responsible for administration of medicines. The activities programme is facilitated by a staff member undertaking diversional therapy training. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged and van outings are arranged on a regular basis. All food is cooked on site, residents nutritional needs are identified, documented and choices are available. The menu was reviewed by a dietitian in 2012. There is an improvement required around care planning.

### Outcome 1.4: Safe and Appropriate Environment

The service displays a current building warrant of fitness is current.

## Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are documents to support the policy. Currently there are no residents requiring restraint or enablers. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

## Outcome 3: Infection Prevention and Control

There is an established and implemented infection control programme that is linked to the quality system with monthly reporting of surveillance data being undertaken.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	18	0	0	1	0	0
Criteria	0	47	0	0	1	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	31
Criteria	0	0	0	0	0	0	0	53

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	Three of five files reviewed evidenced the following: a) One care plan described wound management, however the wound plan reported the wound had	Changes in health status and associated interventions are updated in the care plan to reflect the resident health needs.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>healed, b) one care plan described the intervention for managing a hypo/hyperglycaemic event (resident non-insulin), however did not define the blood sugar level that would trigger the intervention, noting a BSL of XXXX, c) one resident had weight loss of XXXX months (also reported by the GP), the care plan does not reflect the interventions to support weight gain/stabilisation. The same resident had XXX reported by the GP who prescribed XXXX, there was no pain assessment/monitoring documentation in place. The resident exhibits challenging behaviour and while there was a behaviour plan in place, the care plan did not indicate issues with challenging behaviour A visiting regime was in place with this resident, the care plan does not outline interventions if the visiting regime is breached.</p>		

## 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; D16.1b.ii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** FA

#### Evidence:

There is a policy to guide staff on the process around open disclosure and interpreter services. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Seven of seven incident forms reviewed (between April and June) identify family were notified following a resident incident. Interview with two caregivers the registered nurse and duty manager inform family are kept informed. There is one couple in the facility who speak minimal English and there is evidence of family involvement in care matters. Interpreters can be accessed if necessary (verified by owner).  
D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry  
D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  
D16.4b relatives (one) stated they are informed when their family members health status changes.  
D11.3 The information pack is available in large print and this can be read to residents.

### 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:**

The informed consent policy includes responsibilities and procedures for staff. Informed consent information is provided to residents and their families on admission. This is also discussed with residents and their families during the admission process. Two caregivers interviewed are familiar with the code of rights and informed consent when delivering resident cares. There are written general consents in the resident files for photo, release of information and outings. There are appropriately signed resuscitation authorisations in five of five resident files. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. The finding from the certification audit relating to completion of resuscitation forms is met.

D3.1.d Discussion with one family member identifies that the service actively involves them in decisions that affect their relative's lives. Advance directives are completed for residents who are competent to make the decision.

D13.1 There are signed admission agreements in the five files reviewed.

**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.)*

**Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)**

The service is able to demonstrate that written consent is obtained 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 1.1.10.7 (HDS(C)S.2008:1.1.10.7)**

Advance directives that are made available to service providers are acted on where valid.

**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:**

There is a complaints policy to guide practice. The duty manager leads the investigation and management of complaints (verbal and written). There is a complaints (and compliments) register that records activity in an on-going fashion. Complaints are discussed at the two monthly integrated committee meeting and the two monthly staff meeting. The most recent recorded complaint is April 2014 and is seen to have been investigated with an outcome having been provided to the complainant. Discussion with four residents and one relative confirm they are aware of how to make a complaint. There are no other complaints/concerns received during 2014 and nil recorded for 2013. There have been a number of compliments that have been received.  
D13.3h. a complaints procedure is provided to residents within the information pack at entry.

### **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:**

Kolmar Lodge provides care for up to 26 rest home level residents and on the day of audit there were 19 residents at the lodge.

There is a 2014-2015 Business Plan in place. The plan outlines objectives for the period that include a maintenance programme and maintaining occupancy at 95%. There is an implemented quality programme that includes discussion about clinical indicators (e.g. incident trends, infection rates), at the bimonthly integrated committee meeting and again at the two monthly staff meetings. The duty manager (non-clinical) reports through to the owner (interviewed during the audit) and is supported by a charge nurse (RN) who works 25 hours/week, and a registered nurse who work six hours per week (and lives onsite). There is registered nurse on call 24/7. The registered nurses have appropriate experience to meet the clinical needs of the residents. There is a team of experienced care staff.

The duty manager has been in post for four years and has worked at Kolmar for seven years (previously as a caregiver) and works approximately 25 hours per week. She will be reducing hours in August and interview with the owner informs recruitment to cover the position is underway.

D17.3di, the duty manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

**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:**

Kolmar Lodge is implementing a quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff.

Quality matters are taken to the bimonthly integrated committee meetings and then to the bimonthly staff meetings that all staff are invited to attend. Meeting minutes demonstrate key components of the quality management system are discussed including internal audit, infection control, incidents (and trends) and in-service education. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff. Meeting minutes reviewed indicate issues raised are followed through and closed out, including resident meetings (three monthly).

Kolmar Lodge is implementing an internal audit programme that includes aspects of clinical care – such as medication audit. Issues arising from internal audits are reported on the Moving on Audits Action Sheet and are seen to have been closed out.

D19.3: There is a Health & Safety and risk management programme in place including policies to guide practice. The duty manager is the health and safety coordinator for the facility. Staff accidents and incidents are monitored.

D19.2g: Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. The service has lifting belts, hip protectors and access to sensor mats if necessary.

#### 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:**

D19.3c: The service collects incident and accident data and reports aggregated figures monthly to the staff meeting. Incident forms are completed by staff, the resident is reviewed by the registered nurse (RN) at the time of event if she is on site, and is notified by care givers of incidents afterhours. Family are notified by the charge nurse (RN). Seven incident forms were reviewed between April and June and all had been completed appropriately. The five files reviewed demonstrate all reported incidents had an accompanying incident form.

D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.

Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.

### 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:**

There are human resources policies to support recruitment practices. The charge nurse (RN) and registered nurse's practising certificates are on file. Six staff files were reviewed (three caregivers – one is a senior, the duty manager – who oversees the activities programme, the charge nurse – who is the infection control and restraint coordinator, and the registered nurse) and all had relevant documentation relating to employment. Performance appraisals are current in all files reviewed and the annual practising certificates of the RNs are current.

The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in staff files). Staff interviewed (two caregivers, the charge nurse and duty manager) were able to describe the orientation process and believed new staff were adequately orientated to the service.

There is an annual education plan that includes all required sessions as part of these standards. The plan is being implemented. In addition there are three caregivers who have completed the ACE national certificate. There is evidence of attendance at external training for all staff. Medication competencies are in completed annually for caregivers (and the charge nurse) who are administering medication.

There is a staff member with a current first aid certificate on every shift.

The activities coordinator – who is the duty manager - is completing diversionary therapy training.

### **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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows: two caregivers in the morning (varying time), two during the afternoon (varying time) and one on night shift. The duty manager works approximately 25 hours/week at Kolmar, and the remainder (up to 40 hours) at each of the other two facilities. The charge nurse works approximately 25 hours/week and the second RN six hours/week (and lives onsite). The RNs and duty manager are on call afterhours dependant on the presenting issue. The activities programme is delivered primarily by the caregivers. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident's individual record. An initial care plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. D7.1 Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Policies contain service name. The finding from the previous certification audit relating to incorrect filing of resident information is considered to be met based on the files (and associated information) reviewed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

**Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)**

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

**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 1.2.9.9 (HDS(C)S.2008:1.2.9.9)**

All records are legible and the name and designation of the service provider is identifiable.

**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 1.2.9.10 (HDS(C)S.2008:1.2.9.10)**

All records pertaining to individual consumer service delivery are integrated.

**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:**

D16.2, 3, and 4: The five resident files reviewed show an initial nursing assessment and care plan was completed within 24 hours and a long term care plan was completed within three weeks. The care plans are reviewed by the charge nurse. Four of five care plans evidence evaluations completed at least six monthly, one resident has not yet been at the service for six months. Current health changes have not always been updated into the care plans (link 1.3.6.1). Activity assessments and the activities plans have been completed. Four residents interviewed state they and/or their family were involved in planning their and at evaluation. Resident files include a 'discussion with family' sheet which is completed in all resident files sampled.

D16.5e: All resident files reviewed identify the GP saw the resident within two working days of admission. It was noted in resident files reviewed that the GP has assessed the residents as stable and is to be seen three monthly. More frequent GP review was occurring on review of resident's files. The GP was unable to be contacted during the audit.

A range of assessment tools are completed in resident files on admission and six monthly including (but not limited to); a) falls risk assessment, b) pressure area risk assessment, c) dietary profile, d) challenging behaviour assessment (if appropriate). Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery (observed). Five files reviewed identified integration of allied health and a team approach is evident.

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

Tracer Methodology

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** 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:**

### **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:** PA Moderate

**Evidence:**

Five resident files were reviewed (and an additional file of a resident experiencing pain was checked). An initial nursing assessment and care plan were completed within 24 hours and a long term care plan completed within three weeks in all files. The care plans are completed and reviewed by the charge nurse (RN) in four of the five files sampled (one was not due for review). In three of the five files, current changes to health status has not been recorded in the care plan, and this is a required improvement.

Four of five care plans evidenced evaluations completed at least six monthly (including lifestyle plan), and one rest home resident has not yet been at the service for six months. Activity assessments and the activities plans have been completed. The care being provided is consistent with the needs of residents – verified by interview with four residents and one family member, charge nurse (RN) and duty manager. A review of short (wound) term care plans, long term care plans, evaluations and progress notes demonstrate integration. There is evidence of three monthly medical review.

Care delivery is recorded in the progress notes at very shift (evidenced in five residents' files reviewed) by either the caregivers and/or charge nurse. The charge nurse documents in the progress notes when there is a change in the resident's condition or health need (sighted and interview). Two caregivers and the charge nurse (RN) inform they have sufficient equipment to provide care, including wheelchairs, commodes, shower chairs, continence supplies, gowns, masks, aprons and gloves and dressing supplies. Staff confirm there is adequate continence and dressing supplies. Four residents and one family interviewed are complimentary of care received at the facility.

D18.3 and 4 Dressing supplies are available. Wound assessment and wound management plans are evident, at the time of audit there are no wounds at the facility. Wound management in-service has been provided in May 2014.

The charge nurse (RN) interviewed described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a continence assessment (where relevant) and products identified for day use, night use. Specialist continence advice is available as needed and this could be described.

During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' privacy. Residents interviewed were able to confirm that privacy and dignity was maintained.

### **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:** PA Moderate

#### **Evidence:**

Five resident files reviewed identified an initial nursing assessment and care plan was completed within 24 hours and the long term care plan was completed within three weeks. The care plans are reviewed and evaluated by the charge nurse (RN) six monthly, and in three of five files the current health changes have not been consistently updated into the plan – one resident has not been in the service for six months. Goals and interventions are recorded in the care plans. Activity assessments and the activities care plans have been completed. The care being provided is consistent with the needs of residents, confirmed by interview with four residents and one family, the charge nurse and duty manager.

There is evidence of three monthly medical review. Care delivery is recorded and evaluated in the progress notes at very shift (five of five resident files). When a resident's condition alters, the charge nurse (RN) initiates a review and if required, arranges a GP visit. Two caregivers and the charge nurse (RN) interviewed state they have all the equipment referred to in care plans and necessary to provide care, including wheelchairs, pressure mattresses, commodes, shower chairs, continence supplies, gowns, masks, aprons and gloves and dressing supplies. The charge nurse (RN)s described the referral process and related form for referral to a wound specialist or continence nurse. Continence products are available and resident files include a urinary continence assessment and continence products identified for day use, night use. Specialist continence advice is available as needed and this could be described.

#### **Finding:**

Three of five files reviewed evidenced the following: a) One care plan described wound management, however the wound plan reported the wound had healed, b) one care plan described the intervention for managing a XXXXX), however did not define the XXXX that would trigger the intervention, XXXXXX, c) one resident had XXXXXX recorded across two months (also reported by the GP), the care plan does not reflect the interventions to support XXXX. The same resident had groin pain reported by the GP who prescribed XXXXX, there was no pain assessment/monitoring documentation in place. The resident exhibits XXXXX and while there was a behaviour plan in place, the care plan did not indicate issues with challenging behaviour A visiting regime was in place with this resident, the care plan does not outline interventions if the visiting regime is breached.

#### **Corrective Action:**

Changes in health status and associated interventions are updated in the care plan to reflect the resident health needs.

**Timeframe (days):** 60 (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 duty manager (who is completing diversional therapy training) is responsible for the planning the activities programme at Kolmar in conjunction with the care staff. Delivery of the programme is undertaken primarily by care givers. There is a 24 hour programme that includes 1:1 activity. A programme is displayed in the facility. Activities are provided in the lounge areas and one on one input in resident's rooms when required. On the day of audit residents were observed being actively involved in the activity programme. Residents have an activities assessment completed over the first few weeks after admission developed into the activities plan. An attendance record is kept maintained for each resident and progress notes completed. Review and evaluation of the activities plan is completed six monthly. The resident/family/EPOA as appropriate is involved in the development of the activity plan. The programme includes residents being involved within the community. There is a range of activities offered that reflect the resident needs including but not limited to bingo, quizzes, crafts, outings, music and shopping. Participation in all activities is voluntary. Resident satisfaction survey (last completed September 2013) reported satisfaction with the activities programme.

Residents interviewed describe attending the various activities outings. Kolmar has access to a van from one of the other owner's facilities. The van driver has a current first aid certificate and driver's license.

D16.5d: four resident files reviewed identify the individual activity plan is reviewed around the time of the care plan review. One resident file reviewed had been in the facility less than six months.

### 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:**

There is at least a three monthly review for residents by the medical practitioner. D16.4a Care plans are reviewed and evaluated by the RN six monthly (link 1.3.6) – sighted in four of five files reviewed - one resident has not yet been at the service for six months. There are short term care plans to focus on short-term issues such as skin tears. Challenging behaviour plans are in place. Short Term Care Plans show evaluation and are signed and dated by the charge nurse when issues have been resolved. Staff are informed of any changes to resident need at handover between shifts. Caregivers interviewed confirm they are updated as to any changes in resident's care or treatment during handover sessions which occur at the beginning of each shift and this was observed during the audit.

ARC D16.3c: All initial nursing assessment/care plans were evaluated by an RN within three weeks of admission.

D16.4a Care plans are evaluated six monthly (link 1.3.6).

### 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:**

Medication policies align with accepted guidelines. Medications are stored in a locked cupboard and taken from the 'roll' on a trolley during the medication administration. There are no controlled drugs at the time of audit. Six monthly pharmacy audit occurs. The service uses two weekly blister packed medication management system. Medication charts have photo ID's. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There are no resident's self- administrating medications. There are standing orders signed by the GP. Staff sign for the administration of medications on medication signing sheet. 10 administration sheets sampled correlate with prescribed instructions. The medication folder includes a list of specimen signatures. Medication profiles are legible, up to date and reviewed at least three monthly by the GP. Residents/relatives interviewed state they are kept informed of any changes to medications. The medication chart has alert stickers for; a) allergies and b) duplicate name. Caregivers administer medicines and the charge nurse when required. All have been assessed as competent. One senior caregiver was observed administrating medications with correct procedure including checking the GP prescription chart and signing correctly for the medication. There were two findings from the certification audit that related to prescribing of over the counter medications and specimen signatures on signing sheets. Both of these have now been met – the former verified via a prescription of glucosamine and fish oil.

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

### **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:**

Kolmar cooks all food on site. There is one cook that work full time across a split shift so she is on site to manage the evening meal. The cook (interviewed) has been employed at the service for 13 years and has recently completed food safety training (refresher – April 2014). Caregivers assist in the kitchen. During the day caregivers help with the dishes. There is a four weekly rotating winter and summer menu. The menu was last reviewed by a dietitian in 2012 and is due for review this year.

A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. The food is prepared and served from the kitchen and then covered and taken to the second dining area. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food in the freezer and fridge is labelled or dated and stored correctly.

The residents have a diet profile developed on admission (and reviewed six monthly), which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs are communicated to the kitchen. Special diets are noted on the kitchen notice board, which is able to be viewed only by kitchen staff. The cook reports that the only special diets are diabetic, and this relates to deserts. Weights are recorded monthly as directed by the RN (link 1.3.6). Residents are invited to give feedback regarding food services at the three monthly residents meetings. Lunchtime meals were observed being served and were attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required and individual resident likes and dislikes are noted on the notice board in the kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks. A food satisfaction survey was completed in March (2014) and the surveys reviewed reported residents are satisfied/very satisfied with the food provided.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The service displays a current building warrant of fitness dated 16 March 2014. The findings from the certification audit have now been met including: the pavers that were in the front car park have been replaced by concrete and there is a chain across the external and internal stair cases preventing resident access.

### 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.)*

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

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### 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:**

Kolmar has policies and procedures on restraint minimisation and safe practice. The charge nurse is the restraint coordinator and confirms that the service promotes a restraint-free environment. Policy states that enablers are voluntary. There are no residents using enablers and no residents assessed as requiring restraint. Policy includes guidelines for use of enablers and restraint. Policy also includes definitions for restraint and enablers. There are procedures for restraint if it should be required and associated documentation to support the policy including a restraint register, restraint/enabler assessment forms, restraint/enabler consent forms, a restraint/enabler plan of care, monitoring forms, and three-monthly evaluation forms. Restraint is included in the bimonthly integrated committee meeting. An annual review of restraint is completed – last done November 2013. Restraint education is provided annually and was last provided for staff in January 2014. The finding from the certification audit relating to the key pad code being incorporated into policy has now been 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

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### 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:**

There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (charge nurse) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infections are included on a monthly register and a monthly report is completed. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme. Infection control and hand washing are included in the audit schedule (last completed April). There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.

#### 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.)*