# Kamo Home & Village Charitable Trust

## Current Status: 9 September 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

The Kamo Home and Village is operated by a charitable trust board. The service offers rest home, hospital and dementia level of care for up to 70 residents. On the day of audit 67 beds are occupied; 28 rest home, 15 hospital and 24 beds in the specialist dementia unit.

There were two areas requiring improvement identified at the previous audits; these areas are now addressed with the implemented improvements embedded into practice related to documentation in residents’ files and medicine management. There are no new areas requiring improvement identified at this unannounced surveillance audit.

The service has appropriate organisational management and quality systems in place to ensure care and services are provided to meet the needs of the residents at the different levels of care. Staffing levels and skill mix are maintained to meet safe indicators for aged care and dementia services and exceed the minimum contractual requirements. Residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. Services demonstrate that the use of restraint is actively minimised.

## Audit Summary as at 9 September 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 9 September 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 9 September 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 9 September 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 9 September 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 9 September 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 9 September 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:** | Kamo Home and Village Charitable Trust |
| **Certificate name:** | Kamo Home & Village Charitable Trust |

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

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Kamo Home and Village |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| **Dates of audit:** | **Start date:** | 9 September 2014 | **End date:** | 10 September 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:** | 67 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **Hours on site** | 12 | **Hours off site** | 4 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 20 | Total audit hours off site | 10 | Total audit hours | 30 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 6 | Number of managers interviewed | 3 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 4 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 78 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed |  |

## **Declaration**

I, XXXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Tuesday, 7 October 2014

## **Executive Summary of Audit**

**General Overview**

The Kamo Home and Village is operated by a charitable trust board. The service offers rest home, hospital and dementia level of care for up to 70 residents. On the day of audit 67 beds are occupied (28 rest home, 15 hospital and 24 in the specialist dementia unit). There were two areas requiring improvement identified at the previous audits; these areas are now addressed, with the implemented improvements embedded into practice related to documentation in residents’ files and medicine management. There are no new areas requiring improvement identified at this unannounced surveillance audit.

The service has appropriate organisational management and quality systems in place to ensure care and services are provided to meet the needs of the residents at the different levels of care. Staffing levels and skill mix are maintained to meet safe indicators for aged care and dementia services and exceed the minimum contractual requirements. Residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. Services demonstrate that the use of restraint is actively minimised. There is a managed environment, which minimises the risk of infection to residents, staff, and visitors

**Outcome 1.1: Consumer Rights**

Residents and their families are informed of their rights during the admission process and time is set aside for discussion on an ongoing basis. An interpreter is available if required for residents of different ethnic groups.

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

**Outcome 1.2: Organisational Management**

The management ensures that services are planned and coordinated to meet residents' needs. The organisation's strategic and business plans identify their purpose, values, priorities and goals. The planning process is reviewed annually and evaluated quarterly to measure achievement.

The day to day operation of the facility is undertaken by staff who are appropriately experienced and qualified to undertake the role in a manner that ensures residents' needs are being met in a safe and efficient manner.

All quality and risk management processes are implemented to meet organisational requirements. Policies and procedures reflect current accepted good practice. All quality actions are recorded and reported at staff and management levels. Key components of service are explicitly linked to the quality management system. Quality data collection and findings are used as opportunities for improvement which are well documented. Quality improvements, corrective actions and preventative actions are evaluated to ensure the desired outcomes are reached.

There are systems in place to monitor hazards and risks. Incidents, accidents and untoward events are recorded, evaluated and discussed with family/whanau in a manner that is reflective of open disclosure principles.

The organisation has processes in place for the employment, recruitment and ongoing education and professional development of staff. Staffing levels and skill mix are maintained to meet recommendations and exceed contractual requirements. Staffing is planned to meet the needs of the residents at rest home, hospital and dementia levels of care.

The area for improvement relating to the use of the daily care sheet and lack of integration onto progress notes has been addressed. Evidence is seen of up to date documentation on the progress notes.

**Outcome 1.3: Continuum of Service Delivery**

The provision of services is delivered by suitably qualified and experienced staff. The general manager or registered nurse conducts the initial assessment and care plan on the resident’s admission to the service. The provision of care is based on the assessed needs of the resident, for residents at rest home, hospital or dementia level of care. Care plans are evaluated at required six monthly intervals or earlier if the assessed needs change.

The activities are planned to meet the needs and strengths of the residents. This includes the use of the Eden Alternative Concept in all levels of care.

The menu is reviewed by a dietitian and has been assessed as suitable for the older person living in a care facility. All other aspects of food delivery meet food service delivery standards requirements.

A safe medicine management system is observed on the day of audit. Staff who are responsible for medicine management are assessed as competent to perform the role. All aspects of medicine management meet safe medication standards. The previous area for improvement has been addressed relating to three monthly review of medication charts by the GP.

**Outcome 1.4: Safe and Appropriate Environment**

The facility has a current building warrant of fitness. There are no alterations to the layout of the building since the last audit.

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

The service has six residents requiring enabler use at the time of audit. Where enablers are used, these are voluntary and the least restrictive option for the resident. Staff are able to demonstrate their understanding of the restraint minimisation policy and procedures and the definition of an enabler. The internal and external space in the specialist dementia unit allows maximum freedom of movement while promoting the safety of residents who are likely to wander.

**Outcome 3: Infection Prevention and Control**

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. 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. There is external benchmarking of the infections surveillance rates.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 17 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 62 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

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

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

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

## **Outcome 1.1: Consumer Rights**

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

#### Standard 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** FA

**Evidence:**

The service is maintaining its open disclosure practices and residents and their relatives are fully informed about all and any events. Resident and relative feedback confirms they feel fully informed in all aspects of the service provision. Staff wear name badges to assist residents and relatives with identification. There are no residents for whom English is a second language but an interpreter is available as required. DHB interpreter services contact details is displayed in the office.

 ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.1.13: Complaints Management  **(**HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

**Attainment and Risk:** FA

**Evidence:**

Complaints management is explained as part of the admission process. The complaints process is documented in policy, on a flow chart and is provided in the resident welcome book. The sighted complaints procedure is easily accessible, responsive and complies with Right 10 to the Code of Health and Disability Services Consumers Rights (the Code). As observed at the time of audit, complaints forms and complaints boxes are displayed and available throughout the facility.

The complaints register identifies that to date in 2014 there are five low risk complaints. The complaints register contains the complaint number, dates, item, description of the complaint, review dates and when finalised/cleared. The complaints sampled evidence they are addressed within times frames that comply with Right 10 of the Code (with the sampled complaints finalised on the same day or next day after the complaint was received).

Interviews with the three of three family/whanau which includes a family member of a resident living in the dementia unit) and seven of seven residents (six rest home and one dementia unit resident, with three of the rest home residents living in the studio apartment section of the service) confirms their understanding of their right to make a complaint.

The relevant Aged Related Residential Care (ARRC) service agreement requirements with the District Health Board (DHB) are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The services are planned and coordinated to meet the needs of the residents requiring rest home, hospital and specialised dementia level of care. The mission, vision, values, philosophy and purpose are clearly shown. The strategic plan documents long term, medium term and short term strategies to achieve set goals and mitigate known risk to all areas of service delivery. The business plan focus for 2014/2015 sighted includes goals in the environment, service provision and human resources, which is linked to the overall long term strategic plan. The business plan is reviewed annually by the Board of Trustees. Organisational performance is monitored against identified values, goals and purpose through the Board of Trustees. Strengths, risks and opportunities are clearly identified. Key performance indicators are developed to match the business plan and reported and measured as identified on the balance score card and external benchmarking (results sighted).

The general manager is a registered nurse (RN) who has been in the role for approximately five years. The job description identifies the level of authority, accountability and responsibility for the provision of services (personnel file sighted). The general manager’s role is supported by a management team of three (the quality and risk manager, the resident and lifestyle manager and the clinical care services manager). The general manager maintains both clinical and business management skills through on-going education which is documented in the training file. Examples sighted for the past year include health and safety representative training, interRAI training, business excellence assessor training and holding the required level of expertise in the professional development recognition programme through the District Health Board (DHB). The general manager is a member of an aged care association and employment association, and receive regular training and updates from these organisations related to management of the service. The general manager has in excess of eight hours education in the management of aged care service in the past 12 months.

The ARRC service agreement requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The six staff interviewed (one RN, one senior caregiver, two caregivers, one activities staff, and one cook) and three members of the management team demonstrate an understanding of the quality and risk processes that are identified in policy. 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 and reflect legislative changes.

There is a monthly quality register of the scheduled internal audits. Each quality checklist has set target goals for compliance. The compliance is monitored as part of the ‘balance score card’ quality targets. The quality activities, quality outcomes and care matrix targets are reviewed and analysed at least three monthly. The service externally benchmarks their data with a quality performance systems organisation. This external benchmarking occurs three monthly. The service also provides data to the DHB as part of the ‘First Do No Harm’ project.

Key components of service delivery are linked to the quality management system. There is a three monthly quality review that covers clinical safety, clinical practice, human resources management, mandatory updates, health and safety, education and quality monitoring of incident forms and complaints. The internal audits cover the range of services provided. The sampled clinical audit check, conducted in August 2014, documents the findings (positive and area for improvement), the actions taken, and follow up by the quality coordinator. This evidences that all areas identified for improvement have been implemented and monitored for effectiveness. Quality data is analysed and evaluated by the quality manager. Results are discussed at the staff meetings and where ongoing actions or preventative actions are required, these are incorporated into staff training.

The quality improvement data collected is analysed and evaluated and trended by the quality team. If a trend is noted to be increasing (negatively) then corrective action planning is put in place as required, using the audit evaluation form and corrective action request/report forms. The services ‘improvement model’ for corrective and preventive procedures includes review of the root cause and analysis of any problems/issues that require improvements. The opportunities for improvement may be identified through analysis of quality reports, observed actions, through the internal auditing systems or feedback from staff, residents and relatives. In addition to the ‘plan, do, check and act’ quality cycles, the service then reflects on, and evaluates, the improvements implemented.

Actual and potential risks are identified in the sighted hazard register. The hazards and risks are documented and communicated to staff and residents as appropriate. The system used by the service identifies all hazards and if they cannot be eliminated they are added to the hazard register. The register records how the hazard can be minimised or isolated and the actions to reduce the risk of an incident occurring.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The facility manager and quality manager interviewed understands their obligations in relation to essential notifications and the correct authority is notified where required.

The staff are required to complete incident and accident reports for any actual or near miss accident/incident. The hard copy form is completed and the incident/accident is also recorded on the electronic quality management system. The six staff interviewed understand their responsibilities on how and when to complete the incident/accident forms. The incident and accident forms sighted as part of this surveillance audit evidence that the adverse, unplanned, or untoward events are documented and used to identify opportunities to improve service delivery, and to identify and manage risk. The analysis of the data includes identifying re-occurring incidents, for example a resident who has had more than one fall, and corrective and preventive actions are documented. Where ‘frequent fallers’ are identified, this is linked to the care planning for the resident, with interventions implemented to reducing the risk of fallings.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The professional qualifications, including evidence of annual practising certificates and scope of practice, are sighted for all staff who require them. A copy of the annual practising certificate (APC) is sighted in the three RNs’ files reviewed (including the general manager), with an electronic record maintained of when the APC requires renewing.

The six staff files reviewed (the general manager (RN), two other RNs, two caregivers and one cook) evidence appropriate recurrent and on-going performance reviews to ensure staff safety training meets the needs of the residents. The six of six staff files reviewed evidence an orientation to the essential components of the service, which is also confirmed at interview with the six staff. The induction process for the care staff includes competency assessments. The competency assessment assesses the staff to varying levels (eg, requires supervision with the task, can perform on their own or can perform and also support/guide others in the task). All the care staff personnel files (two RNs and four caregivers) reviewed indicated they are able to perform their role independently or can perform the role and support others in their performance. The personal file reviewed of the kitchen assistant includes an induction checklist that covers the key components of the service and kitchen services.

The education calendar and individual staff members education records include the required education and training for the care staff. Each RN has an area of speciality, which is required to be included in the training calendar at least twice a year (for example, infection prevention and control, restraint mitigation, health and safety, falls management). The education topics include manual handling, restraint minimisation, challenging behaviours, wound care, first aid and CPR, care planning and assessment skills, communication, falls management, specific medical conditions and caregiver and RN competencies. The service also accesses on-going education through the DHB and local hospice service. The care staff who work in the dementia unit have completed or are enrolled in the required national unit standards.

The ARRC requirements are met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Staffing levels are based on the safe indicators for aged care and dementia care SNZ HB 816:2005. The general manager reports that the allocation and skill mix of the staff is reviewed weekly to ensure the minimum staffing levels are achieved. The current roster sighted for the rest home, hospital and dementia unit indicates a surplus of 54 care staffing hours in the rest home/hospital and 49 hours in the dementia unit. There is an additional one non clinical shift per week for each of the RNs to focus on their area of responsibility. The general manager reports that these are minimum staffing levels and that the service has the flexibility and staff to increase staffing to meet any additional needs of the residents. At the time of audit there are four hospital level of care residents in the studio apartment area (an attached wing the rest of the service) and these residents receive the appropriate level of care and staff skill mix to meet the resident’s needs.

A review of four weeks rosters identifies that both the dementia unit and the rest home and hospital wings are staffed to ensure there is a skill mix and sufficient numbers of staff to meet residents' needs. All sick leave and annual leave is shown and replacement staff noted. The current staffing for the current 67 residents - 28 residents at rest home level of care, 15 at hospital level of care (which includes the studio apartments) and 24 in the dementia unit is as follows: morning shift: one RN for the rest home and hospital, one RN in the dementia unit, one senior caregiver and seven caregivers (three of the caregivers are rostered to the dementia unit)

afternoon shift: one RN across the facility, one senior caregiver and seven caregivers (three caregivers are rostered to the dementia unit)

night shift: one RN and three caregivers (with one caregiver rostered to the dementia unit).

The clinical management team are onsite during week days. There are adequate diversional therapy, physiotherapy, cleaning, laundry and kitchen staff to meet the residents' needs. Interviews with one RN and three caregivers (one being a senior caregiver) confirms that they have sufficient time to complete all tasks to meet residents’ needs. Interviews with seven of seven residents and three of three family/whanau members confirm they are very happy with service provision and that staff always respond to the call bell within an appropriate time frame. The interviews include three residents who receive care in the studio apartments, and all confirm satisfaction with the care and services provided.

There is a retirement village on the grounds, as well as a studio apartment wing that is attached to the aged care facility. The staffing for the retirement village and residents in the independent studio apartments who do not receive either rest home or hospital level of care, is separate to that of the staffing allocation for the aged care services. When a resident of the studio apartment is assessed as requiring either rest home or hospital level of care, the occupational right agreement is terminated and the resident receives care and services according to the aged related residential agreement.

ARRC 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.)*

#### 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:**

Evidence is seen of resident information being entered in the documentation system within timeframe requirements. Evidence is seen of changes in the resident’s care status being documented in the progress daily. The previous are for improvement has been addressed. ARRC requirements have been met.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## **Outcome 1.3: Continuum of Service Delivery**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Service delivery documentation is overseen by the General Manager (GM) and the registered nurse (RN). Documentation is part of the audit process and reviewed at regular intervals to ensure this is completed within required timeframes. In the six files reviewed (one hospital, three rest home, two dementia) there is evidence of initial assessments and care plans being completed and clinical risk tools being reviewed within the required timeframes.

The RN reports there is a process for annual multidisciplinary resident reviews or review occurs earlier if required. There is evidence in the six files reviewed that family/whanau are involved in all areas of care management. Kamo Home have the services of a GP who visits twice weekly or at other times if required. The GP is on call cover 24 hours a day, seven days a week (24/7), for all residents.

The RN reports that Community Geriatric Services from the Northland District Health Board (NDHB) visit as required. Referrals are made to a dietitian for any unexplained weight loss.

The seven residents and three relatives interviewed are very positive about the staff, GP and all aspects of care. The six clinical staff interviewed (one RN, three caregivers, one activities co-ordinator, one cook) report that they are kept up to date with all clinical changes.

ARRC 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.*

Tracer Methodology Dementia Level Care:

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

.Tracer Methodology Hospital Level Care:

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

In the six files reviewed there is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are evaluated at required timeframes to ensure residents’ desired outcomes are being met. Evidence is seen in documentation of a resident whose falls risk assessment had changed from low to medium risk. Changes to the care plans included regular checking of the resident, leaving the resident’s bell accessible and a sensor mat if the resident gets out of bed without ringing the bell.

The six clinical staff interviewed report they are informed of any care plan changes at hand over and have relevant in-service education as required.

ARRC 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:**

There is one full time Lifestyle Manager, one full time and one part time activities coordinator employed at Kamo Home. Activities are available for all residents over seven days a week as the caregivers undertake activities during the hours when the activity staff are not on site.

The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents. During interview the activities coordinator reports that it is important to have activities at similar times as the residents appreciated the routine.

External visits for the residents include picnics, beach trips and van trips. The seven residents and three family members report on interview that the activities are positive and include exercise and music. Favourite activities are reported to be the monthly theme events and entertainment. Evidence is seen of themes events which include an island day, daffodil day and baking.

The lifestyle care plan is completed and reviewed six monthly. Evidence is seen of monthly resident meetings and annual resident satisfaction surveys.

ARRC 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:**

Individual short term care plans are seen for wound care, infections and weight loss. These are kept in the resident’s folder and each shift documentation is made in the file as required. These are transferred to progress notes when completed or transferred to the long term care plan.

Long-term care plans are reviewed every six months or earlier as required. Evidence of this was sighted in the six files reviewed. Progress notes are signed each duty by caregivers and weekly by the RN. Evidence is seen of the family/whanau involvement in the care reviews. In all six files reviewed evidence is seen of documentation if an event occurs that is different from expected and requires changes to service. The seven residents and three family members interviewed report that they are given the opportunity to be involved in all aspects of care and reviews.

The six clinical staff interviewed have knowledge of the care plan documentation requirements.

ARRC 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:**

Kamo Home uses the blister pack medicine system whereby medicines are delivered weekly except for ‘PRN’ (pro re nata) medication which are delivered as required. When the blister pack medicines are delivered they are checked by the RN and evidence is seen of the signing sheet. There are controlled drugs on the premises and all processes comply with the legislative requirements.

There is evidence in all twelve files reviewed that medication charts are reviewed three monthly by the GP or as required.

Standing orders are not used at this facility.

Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The RN reports that the GP works with the pharmacy but he is responsible for all medicines administered to his residents. If medicine is brought in by family this is approved by the GP and he charts on the medication sheet.

The RN and competent caregiver are responsible for all medication rounds. Evidence is seen of the designated staff having up to date competency for medicine management and administering medicines.

There is no self-administration of medicines at Kamo Home.

Medicine sheets are signed in ink as required following administration.

The previous area for improvement relating to the GP not consistently reviewing all medication sheets has been addressed.

ARRC 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:**

Kamo Home operates a seasonal menu cycle approved by a dietitian (sighted). An individual dietary assessment is completed on admission which identifies individual needs and preferences. Morning and afternoon teas are prepared in the kitchen and snacks are available over 24 hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans.

The service is managed by three cooks over seven days. Evidence is sighted of meal planning, cleaning routine and audit requirements being completed. All cooks are up to date with their food safety certificate. Evidence is seen of attendance at annual update education on infection control and first aid. The cook reports on interview that he is supported by management with food supplies and understands the individual requirements of the residents.

The cook reports that at present all residents have a normal texture diet and there are no soft diets. Evidence is seen of diabetic diets, residents who are receiving supplements and residents who have food preferences.

ARRC 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:**

The building warrant of fitness expires 1 June 2015. There have not been any alternations to the layout of the service since the previous audit that have required changes to the approved evacuation scheme.

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

At the time of audit there are six residents requiring restraint of enabler use. All documentation, including assessment, approval processes and actions to be taken, are clearly set out should restraint be required. Policy shows that enablers are voluntary and that the least restrictive option would be used with the intention of promoting or maintaining resident independence and safety, such as a chair lap belt to prevent falls, or bedside rails to help the resident feel safe. Observation and staff interviews confirm that no restraint or enablers are in use at the time of audit. The RN and two caregivers interviewed demonstrate knowledge that enablers use is voluntary and the least restrictive option for the resident.

There is one restraint use in the specialist dementia unit that requires the intermittent use of a lap belt (this resident is currently being re-assessed for potential hospital level of care). The specialist dementia unit focuses on the promotion of quality of life that minimises the need for restrictive practices through the management of challenging behaviours.. The internal and external space in the dementia unit allows maximum freedom of movement while promoting the safety of residents who are likely to wander.

The ARCC 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:**

The infection control coordinator has access to infection control information collected within the organisation and has sufficient resources and systems to collect the necessary information. All infections are recorded on the infection report forms, collated once a month, analysed and actions taken as required. Outcomes are presented to staff meetings and any necessary corrective actions are discussed (sighted in the staff meeting minutes). The quality coordinator reports the findings to the clinical care manager. The infections surveillance data is benchmarked quarterly with an external company, with comparison made with other aged care facilities in NZ and Australia (benchmarking report sighted).

All care staff members are responsible for the reporting of suspected infections to the infection control coordinator. The data sighted for 2014 records an increase in wound infections in June. The analysis records that this is related to one resident with a re-occurring wound infection, with this resident referred for specialist treatment. The data records that with the interventions for this resident, the number of infections is reduced in July 2014.

##### **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.)*