# Aversham House (2006) Limited

## Current Status: 24 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

Aversham House provides residential care for up to 21 residents. Occupancy on the day of the audit was 18 residents. The facility is managed by a registered nurse who has owned and operated the home for the last eight years. The service has sufficient staff allocated to enable the safe and timely delivery of care.

The seven required improvements from the certification audit around reference checks, medication competencies/documentation, short term care plans, water temperature monitoring, water storage and review of infection control programme have all been closed out. This audit has identified improvements around meeting minutes, compulsory training, aspects of medication management and documentation of interventions.

## Audit Summary as at 24 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 24 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 24 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Continuum of Service Delivery as at 24 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 24 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 24 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 24 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:** | Aversham House (2006) Limited |
| **Certificate name:** | Aversham House (2006) Limited |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance Audit | | | |
| **Premises audited:** | Aversham House | | | |
| **Services audited:** | Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 24 September 2014 | **End date:** | 25 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:** | 18 |

## Audit Team

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

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 12 | Total audit hours off site | 10 | Total audit hours | 22 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 7 | Number of staff interviewed | 6 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 19 | Number of relatives interviewed | 1 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## 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 Tuesday, 4 November 2014

## Executive Summary of Audit

**General Overview**

Aversham House provides residential care for up to 21 residents. Occupancy on the day of the audit was 18 residents. The facility is owner/operated by the current registered nurse/manager for eight years. The service has sufficient staff allocated to enable the safe and timely delivery of care.

The seven required improvements from the certification audit around reference checks, medication competenciies/documentation, short term care plans,water temperture monitoring, water storage and review of infection control programme have all been closed out. This audit has identified improvements around meeting minutes, compulsory training, aspects of medication and documentation of interventions.

**Outcome 1.1: Consumer Rights**

There is an open disclosure policy. Interviews with residents and relative confirm family are kept informed of their family members current health status including any adverse events. A complaints register is in place. There have been no complaints received since the previous audit.

**Outcome 1.2: Organisational Management**

The service continues to implement a quality and risk management framework that includes management of incidents, complaints, infection control surveillance data. There is an implemented internal audit programme to monitor outcomes. There is an improvement required to link audit outocmes to the meeting minutes. The manager is a registered nurse and owner/operator. She is supported by a part-time registered nurse. Both have completed InterRAI training. .

There are human resources policies including recruitment, selection, orientation and staff training and development. The previous finding regarding signed job description and reference checks has been closed out. This audit identified an improvement required staff attending compulsory training.

**Outcome 1.3: Continuum of Service Delivery**

Assessments, care plans and evaluations are completed by the registered nurses. Care plans are individualised and risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are evaluated six monthly. The resident and family confirm they are involved in the care planning process and are complimentary about the staff and standard of care provided. The previous finding around evaluations is closed out. This audit identified an improvement required around the documentation of interventions to reflect the resident’s current needs and risks. Residents and relative interviewed are complimentary of the staff and care received at Aversham House.

The recreational officer provides a five day activities programme for the rest home residents that is varied, interesting and involves community visitors and outings. There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration complete annual competencies and education. The GP reviews the medication chart three monthly. The previous finding around aspects of medication documentation and competencies has been closed out. This audit identified an improvement required around reconciliation of respite care medications and signing of ‘as required’ doses on administration.

The service prepare and cooks all meals on site and the menu has been approved by a dietitian. Individual dietary needs, likes and dislikes are catered for. Residents interviewed responded favourably to the food that was provided.

**Outcome 1.4: Safe and Appropriate Environment**

Aversham House building holds a current warrant of fitness. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is a planned maintenance schedule. The outdoor areas are safe and easily accessible with seating and shade. Previous findings around hot water temperature monitoring and sufficient water store for civil defence have been closed out.

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

The restraint policy and procedure has a clear definition of restraint and enablers. Restraint is used as the last resort. There are currently no residents requiring restraint or enablers.

**Outcome 3: Infection Prevention and Control**

There is an established and implemented infection control programme that is linked to the quality system including monthly reporting and monitoring of surveillance data. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The infection control programme has been reviewed. This previous finding has been closed out.

## Summary of Attainment

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 14 | 0 | 4 | 1 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 4 | 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 | 56 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The outcomes, corrective actions and quality improvements from internal audits are not linked meeting minutes. | Ensure audit outcomes are minuted. | 90 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Not all compulsory training included in the two yearly education planner has been completed which includes code of rights, complaints, infection control, chemical safety and food and safety and hygiene. | Ensure staff attend compulsory training as scheduled. | 180 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | The respite care resident has been in for care four times since May 2014. The nursing assessment has not been reviewed since the initial admission in May 2014. There is no medical history from the GP included in the residents file. | Ensure nursing assessments are reviewed with each admission. Obtain a GP medical history for respite care residents. | 60 |
| 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 Low |  |  |  |
| 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 Low | Five resident files sampled. (i) For the three residents have been assessed as high risk of falls. There are no falls prevention strategies documented in the care plans. (ii) Two residents who identify pain have not had pain assessments completed. There are no pain management interventions documented in the care plans. (iii) One resident recently admitted with a history of weight loss has not been weighed on admission. | (i) Ensure falls prevention strategies are documented. (ii) Complete pain assessments for resident who identify pain and document pain management interventions, (iii) Ensure resident’s weight is recorded on admission. | 60 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | (i) The medication chart for the respite care resident has not been reviewed since the first episode of care in May 2014. Three medications being administered (as per relative list) is not prescribed. (ii) In four out of 10 medication signing sheets there is no dose documented for the administration of PRN medications. | (i) Medication charts are to be reviewed by the GP for each episode of respite care. Ensure medication reconciliation occurs on admission for respite care residents, (ii) Ensure the dose of PRN medication administered is recorded on the signing sheet at the time of administration. | 30 |

## 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 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

**Attainment and Risk:** Not Audited

**Evidence:**

##### Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

**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 1.1.9: 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:**

There is a policy to guide staff on the process around open disclosure and accessing interpreter services. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Incident forms sampled (14) documented family had been notified. Seven residents interviewed inform their family are notified if their health status changes. Families are invited to the three monthly medical reviews. The manager operates an open door policy.   
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 One relative (interviewed) stated that 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. There is an interpreter service available.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The complaints policy guides practice. The RN/manager/owner is the privacy officer and responsible for the investigation and management of complaints (verbal and written). There is a complaints register in place. There have been no complaints since the previous audit. There are letters of thanks and compliments registered. Two caregivers (interviewed) are knowledgeable in the complaints process and resident advocacy and rights. Staff have not attended code of rights, open disclosure and complaints in the last two years (link 1.2.7.5)

D13.3h. A complaints procedure is provided to residents within the information pack at entry. The relative (interviewed) of a resident recently admitted confirmed they received information on the complaints process.

##### 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:**

Aversham House provides rest home care for up to 21 rest home level residents. On the day of audit there were 18 rest home residents. This included one resident who is in for respite care. One resident is currently in hospital.

Aversham Home managed by a registered nurse (RN) who has owned and operated the home for the last eight years. The manager’s husband is a director. The company is supported by an accountant for financial matters and accounts. There is an administration person on-site. The manager is supported by a RN who has been at Aversham House for one year and is employed for 24 hours a week. The RN/manager and RN share the on-call. Both live locally.

The business plan for 2013 has been reviewed and a 2014 business plan and goals developed for 2014. The plan includes quality indicators, person responsible and timeframe for implementation. The goals (including on-going maintenance) are reviewed and signed off as completed. The laundry flooring has been replaced and signed off September 2014. Other goals include review of staff wages, maintaining high occupancy, and improving attendance at staff meetings

ARC,D17.3di (rest home), the manager has maintained at least eight hours annually of professional development activities related to managing a rest home. The manager has completed InterRAI training.

##### 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:** PA Low

**Evidence:**

Aversham House 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. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow implementation by staff.

There are monthly combined quality, health and safety and infection control meetings. Monthly data is provided around accident/incident reports and infections and are linked into the monthly staff meeting minutes (sighted). Two caregivers (interviewed) confirm infections control and incidents/accidents, trends and corrective actions are discussed at staff meetings Information and graphs are displayed. The service has an annual internal audit schedule in place. Corrective action forms are raised for identified quality improvements. There is an improvement required around linking audit outcomes and quality improvements to meeting minutes.

Internal resident/relative surveys are completed. A six week post admission survey is completed by each resident/relative with any concerns follow-up by the manager. The annual survey in March 2014 resulted in three responses with no concerns raised. An individual resident food survey is in progress (including likes and dislikes) that can be collated prior to the menu review by the dietitian.

Resident meetings are held monthly and minutes demonstrate discussion around all services and issues raised are followed up.

D19.3: There is a H&S and risk management programme in place including policies to guide practice. The manager has overall responsibility for Health a.

D19.2g: Falls prevention policies and 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 (link 1.3.6.1).

##### 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:** PA Low

**Evidence:**

The service has an annual internal monthly audit schedule in place that includes medication, resident cares, resident rights, environmental, laundry, infection control and cleaning audits. Corrective action forms are raised for identified quality improvements.

**Finding:**

The outcomes, corrective actions and quality improvements from internal audits are not linked meeting minutes.

**Corrective Action:**

Ensure audit outcomes are minuted.

**Timeframe (days):** 90 *(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 monthly to the quality, health and safety and infection control meeting. Accident/incident data, trends and corrective actions are a set agenda item on the monthly staff meeting. Incident forms are completed by staff and the on-call is notified. Residents with falls are assessed by the RN on call. All incident forms are signed off by the registered nurse or RN manager. Family notification is recorded on the incident form and on the family page in the resident file.

Fifteen incident forms were reviewed from August 214 (seven falls, two soft tissue injury, one near miss fall and five of other category) and seen to have been completed as required. The two caregivers interviewed could discuss the incident reporting process.   
  
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, confirm 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):** 90 *(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:** PA Low

**Evidence:**

There are human resources policies to support recruitment practices. The RN manager and registered nurse practising certificates are current. Five staff files were reviewed (registered nurse, two caregivers, one caregiver/administration and one cook) and all had relevant documentation relating to employment. Signed job descriptions and reference checks are sighted in the five resident files sampled. This is an improvement since the previous audit. Performance appraisals are current in all files. The manager has a performance appraisal schedule in place.   
The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented checklist relevant to the area of work, health and safety induction and infection control questionnaires (sighted in files of three staff appointed between July 2013 and February 2014)). Staff interviewed (two caregivers and the registered nurse) are able to describe the orientation process and believed new staff were adequately orientated to the service.

The RN has completed a 40 hour palliative care course, infection control study day and InterRAI training through external educators. There is a two yearly education plan in place that includes all required education as part of these standards. There is an improvement required around provision of compulsory education.

There is evidence that additional in-service opportunities are offered to staff. Interview with two care givers, the registered nurse, recreational officer and cook confirm in-service education is provided on-site and externally. Caregivers administering medications have completed a competency signed by the registered nurse.   
There is a first aid trained staff member on site at all times. The activities coordinator has a current first aid certificate.

##### 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:** PA Low

**Evidence:**

There is a two yearly education plan in place that includes all required education as part of these standards. The RN has completed a 40 hour palliative care course, infection control study day and InterRAI training through external educators. Interview with two care givers, the registered nurse, recreational officer and cook confirm in-service education is provided on-site and externally. Caregivers administering medications have completed a competency signed by the registered nurse.   
There is a first aid trained staff member on site at all times. The activities coordinator has a current first aid certificate. The manager has registered staff for on-line training and will complete the assessments required for the staff.

**Finding:**

Not all compulsory training included in the two yearly education planner has been completed which includes code of rights, complaints, infection control, chemical safety and food and safety and hygiene.

**Corrective Action:**

Ensure staff attend compulsory training as scheduled.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The human resources policy determines 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. The RN manager is on-site Monday to Friday. The RN is on duty three days a week (Monday, Wednesday and Thursday).

Staffing is as follows for morning shift: one caregiver 7am-3pm, one caregiver 7am-1.30pm and one from 7-10.30am.

Staffing is as follows for afternoon shift: one caregiver 7- 11pm and one caregiver 4-9pm.

There is one caregiver on night shift from 11pm – 7am.

There is a cleaner employed Monday to Friday mornings. The cook works from 8am – 3pm. The recreational officer is employed for 25 hours a week Monday to Friday.

The manager and RN share the on-call. Staff interviewed state they feel supported by the manager and RN who respond quickly to after hour calls.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

There is a policy and process that describe resident’s admission and assessment procedures.   
D16.2, 3, 4: The RN manager or RN on duty is available for clinical assessments of new admissions to the service. The RN undertakes the assessments on admission, with the initial care plan completed within 24 hours of admission. Within three weeks the long term resident care plan is developed.

In five rest home files sampled (four permanent residents and one respite resident) the initial admission assessment is completed. There is an improvement required around nursing assessments for respite care. Three of four permanent resident’s long term resident care plans have been developed reviewed six monthly. One rest home resident has not been at the service long enough for a care plan review. The RN manager and RN have completed InterRAI training and in the process of changing over from the paper based assessments to InterRAI assessments.

The seven residents and one relative interviewed state they are involved in the care planning process. A resident social profile is completed on admission with resident/family/whanau input. Care plans are used by care staff (confirmed on interview) to ensure care delivery meets the residents assessed needs.

There is a verbal and written handover for staff at the beginning of each shift and any resident concerns or events are communicated to the oncoming staff. There is a RN communication book and RN to manager handover sheets. The RN and manager complete a physical walk around daily. Progress notes are completed by the caregivers on each shift. The RN make entries including (but not limited to) GP visits, significant events and assessments completed. All five files identified integration of allied health including general practitioner, nurse practitioner, and needs assessment services for the older person, physiotherapist and podiatrist.

Medical assessments are completed within 48 hours of admission by the GP in four out of five resident files sampled. An improvement is required regarding medical information for respite care. The service has an attending general practitioner GP) based at a local practice. The GP visits twice weekly. There is a GP roster for on-call after hours. The nurse practitioner (NP) interviewed, is employed by the medical centre to provide clinical support to the GPs and rest homes in the area. The NP accompanies the GP for his twice weekly visits which includes three monthly reviews that are due and visiting residents of RN concern. The NP is also available to the facility for one hour a week. She has prescribing rights and is available for home visits on behalf of the GP. The NP maintains a close liaison with the families who are invited to the three monthly reviews. There is good communication between the needs assessors and the district health board. The NP is complimentary of the care at Aversham House commenting on the individual care the residents receive.

Residents (seven) and family/whanau (one) interviewed are positive and complimentary about the staff, clinical and medical care provided.

The five rest home residents files sampled included; (i) resident who has been re-assessed for hospital level of care and awaiting transfer, (ii) respite care resident with left sided weakness (CVA), (iii) resident with wound, (iv) resident recently admitted high risk falls, weight loss and atrial fibrillation, and (v) resident recently admitted with high risk of falls.

Tracer Methodology: Rest home resident

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** PA Low

**Evidence:**

The RN manager or RN on duty is available for clinical assessments of new admissions to the service. The RN undertakes the assessments on admission, with the initial care plan completed within 24 hours of admission. Within three weeks the long term resident care plan is developed. In five rest home files sampled (four permanent residents and one respite resident) the initial admission assessment is completed. Medical assessments are completed within 48 hours of admission by the GP in four out of five resident files sampled. The service has an attending general practitioner GP) based at a local practice. The GP visits twice weekly.

**Finding:**

The respite care resident has been in for care four times since May 2014. The nursing assessment has not been reviewed since the initial admission in May 2014. There is no medical history from the GP included in the residents file.

**Corrective Action:**

Ensure nursing assessments are reviewed with each admission. Obtain a GP medical history for respite care residents.

**Timeframe (days):** 60 *(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:** PA Low

**Evidence:**

Aversham House provides services for residents requiring rest home care. Individualised care plans are completed by the registered nurse. When a resident's condition alters, the registered nurse initiates a review and if required GP or nurse practitioner (NP) consultation or visit. There is evidence documented on the family form of relatives notified for any changes in the residents’ health status including accidents/incidents and infections. Families are invited to GP or NP visits.

There is one resident with a wound on the shin that is clean and recorded as healing well. There is a wound assessment, wound treatment plan and on-going evaluations for the wound.

Continence products are readily available and resident files include a continence assessment identifying products for day and night use. There are adequate supplies of continent products sighted

Risk assessments tools are available for use on admission such as continence, falls, and pressure area and pain assessments. There is an improvement required around pain assessments and falls prevention strategies for residents identified as high risk.

Resident weight is recorded on admission and monitored monthly. A resident’s diet profile is completed on admission. There is an improvement required around weight recordings on admission. The one family/whanau advised on interview that they are involved in the development of the care plan and kept well informed of changes to care or health status and support by staff is consistent with their expectations. There is evidence on the record of family/whanau contact form in the resident file of notification regarding changes of health status, infections, incidents, accidents, GP visits and review of care plan changes. Seven residents interviewed state their needs are being met and they are kept fully informed on their health status. D18.3 and 4; Dressing supplies are available and there are adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment.

##### 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 Low

**Evidence:**

Risk assessments tools are available for use on admission such as continence, falls, and pressure area and pain assessments. Resident weight is recorded on admission and monitored monthly. A resident’s diet profile is completed on admission.

**Finding:**

Five resident files sampled. (i) For the three residents have been assessed as high risk of falls. There are no falls prevention strategies documented in the care plans. (ii) Two residents who identify pain have not had pain assessments completed. There are no pain management interventions documented in the care plans. (iii) One resident recently admitted with a history of weight loss has not been weighed on admission.

**Corrective Action:**

(i) Ensure falls prevention strategies are documented. (ii) Complete pain assessments for resident who identify pain and document pain management interventions, (iii) Ensure resident’s weight is recorded on admission.

**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 service employs a recreational officer for 25 hours a week who has been in the role 10 years. She attends all on-site education and has a current first aid certificate. The recreational officer attends the two monthly local diversional therapy meetings with invited speakers, workshops and networking opportunities. There is a monthly planner of activities, entertainment and outings that is displayed. Each resident has copy. A diary is kept in each resident room (with consent) that records activities and outings or other significant events for resident, staff and family use.

The programme includes (but not limited to); quizzes, music, story reading, bowls, crosswords, exercises (arthritis society), fortnightly Tai Chi (with instructors) and weekly happy hour. There is weekly musical entertainment. The resident enjoy inter-home visits for trivia quizzes, word games and social networking. Community links are maintained with outings to the RSA, community events such as vintage fashion parade and invitations to school shows. There are secondary school visitors, boarders and oversees students who chat and visit residents. Families visit bringing in their pets. Church groups visit regularly to meet with residents, read and reminisce. Interdenominational church services are held monthly. There is a monthly library service for the residents. The service has a van for outings and encourage residents to continue with their community groups providing transport to card groups, senior citizens, fellowship and probus.

Festive occasions and birthdays are celebrated. Daily contact with one on one time is spent with residents who choose not to participate in the group programme or stay in their rooms. The resident social profile is completed on admission and the individual activity plan is in the integrated resident record. Resident meetings are held monthly which includes discussion on activities. Seven residents interviewed enjoy the activities offered, outings and entertainment and are looking forward to the dance event to be held at dance club.

D16.5d: The activity and care plan reviews are completed at the same time.

##### 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:**

All initial assessments and initial care plans are developed by a registered nurse (RN) within 48 hours of admission. The long term care plan is developed within three weeks of admission and evaluated at least six monthly or if there is a change in health status. The RN involves the recreational officer, caregivers and resident/family in the review of the care plan. There is a three monthly review by the GP. Families are invited to the three monthly reviews. There is documented evidence that care plan evaluations are up to date in three of five resident files sampled. One rest home resident has not been at the service long enough for a six monthly evaluation. One resident is a respite care resident. Short term care plans are evaluated and resolved or added to the long term care plan if the problem is on-going as sighted in resident files sampled. This is an improvement since the previous audit.   
D16.4a: Care plans are evaluated six monthly more frequently when clinically indicated.  
ARC: D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

##### 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:** PA Moderate

**Evidence:**

There are policies and processes that describe medication management that align with accepted guidelines. The supplying pharmacy (agreement sighted) is contracted to provide the regular and PRN medication blister packs and other pharmaceuticals. The RN checks the blister pack against the medication chart. Any discrepancies are fed back to the pharmacy. There is an improvement required around medication reconciliation for respite care.

PRN medications have the expiry dates checked monthly. Medications are stored in a central locked medication room. Returns are stored safely. The RNs (includes manager), enrolled nurse and caregiver administer medications. Staff complete medication competencies annually. This is an improvement since the previous audit.

Annual education was attended April 2014. The local hospice provide syringe driver medication for residents who require end of life medication. Controlled drugs are stored in the controlled drug and are supplied weekly by the pharmacist with weekly checks completed. There is currently one resident on controlled drugs. There are no self-medicating residents. Medications requiring refrigeration are stored in the kitchen fridge in a sealed container. The fridge temperature is maintained at 2 degrees Celsius. All eye drops are dated on opening. There is no transcribing on signing sheets. This is an improvement since the previous audit.

The RN is contacted prior to the administration of any prn medications. There is an improvement required around the signing of PRN medications to include the dose given.

Ten medication charts sampled identified all medication charts had photo identification, allergies/adverse reactions noted and special instructions/alerts for administration.

Medications charts are legible and prescribing meets the legislative requirements. All medications are dated on commencement on the medication chart. This is an improvement since the previous audit.

D16.5.e.i.2; Ten out of 10 medication charts reviewed identified that the GP had seen and 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:** PA Moderate

**Evidence:**

The supplying pharmacy (agreement sighted) is contracted to provide the regular and PRN medication blister packs and other pharmaceuticals. The RN checks the blister pack against the medication chart. Any discrepancies are fed back to the pharmacy. Ten medication charts sampled identified all medication charts had photo identification, allergies/adverse reactions noted and special instructions/alerts for administration. Medications charts are legible and prescribing meets the legislative requirements The RN is contacted prior to the administration of any prn medications. .

**Finding:**

(i) The medication chart for the respite care resident has not been reviewed since the first episode of care in May 2014. Three medications being administered (as per relative list) is not prescribed. (ii) In four out of 10 medication signing sheets there is no dose documented for the administration of PRN medications.

**Corrective Action:**

(i) Medication charts are to be reviewed by the GP for each episode of respite care. Ensure medication reconciliation occurs on admission for respite care residents, (ii) Ensure the dose of PRN medication administered is recorded on the signing sheet at the time of administration.

**Timeframe (days):** 30 *(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:**

There are food policies/procedures for food services and menu planning appropriate for the service. The service employs a qualified chef and cook who work a four day on and four days off roster from 8am to 3pm. The caregivers prepare and serve breakfast and heat and serve the prepared evening meal. There is a four week menu in place that has been reviewed by a dietitian. The service has recently conducted a resident survey on the meals to help with the review of the menu.

The service act on resident feedback such as hot plates and smaller meals. Plates are now warmed before serving and those resident requiring smaller meals are now listed on the kitchen whiteboard. The chef/cook receives a resident diet profile (including dislikes) on admission. Alternatives are offered for dislikes. Diabetic morning teas, afternoon teas and desserts are provided. There are currently no special diets or mouli meals. Reviews and change in dietary requirements are communicated to the cook.

The main meal is at midday. Meals are plated and served directly to the dining room. Hot food temperatures (end cooked) on chicken is recorded weekly. All foods sighted in fridges and freezers are dated. Dry goods in the pantry are sealed, dated, labelled and off the floor. Fridge and freezer temperatures are recorded weekly. The kitchen is well equipped with electric and gas cooking. There are cleaning schedules in place. Chemicals are stored safely. The chemical supplier completes checks on the dishwasher. There are screens on the windows.

Residents have the opportunity to provide feedback and suggestions on the menu through resident meetings and surveys.

D19.2; the chef and cook completed NZQA unit 167 October 2013. There is a requirement for al staff involved in the preparing and serving of food to complete food safety and hygiene training (link 1.2.7.5).

##### 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 facility holds a current warrant of fitness which expires on 10 June 2015. Aversham House is single story villa building with safe internal access between the bedrooms and communal areas. The corridors are sufficiently wide enough to allow residents to mobilise with the aid of walking frames. There is safe access to the outdoor areas and gardens with seating and shaded areas. The manager oversees the maintenance and repairs for the facility. There are 24/7 preferred contractors available. Electrical equipment has been tested and tagged September 2014.

ARC D15.3; There is adequate equipment available for rest home level of care. The two caregivers and one RN interviewed state they have all the equipment referred to in long and short term care plans necessary to provide care such as pressure relieving mattresses and cushions, shower stools, transfer belts, wheelchairs, walking frames, mobility aids, an electric bed and wheel-on scales, gloves, aprons and masks.

##### 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:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

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

ARC E3.3d ARHSS D15.3c

**Attainment and Risk:** FA

**Evidence:**

Hot water temperatures in resident rooms and bathroom facilities are checked monthly using a recommended thermometer. The temperatures are stable and are between 42-45 digress Celsius. The previous audit finding has been addressed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

An 800 litre water tank has been installed at the back of the property that is readily accessible. The previous audit finding has been addressed.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

# 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:**

There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The restraint minimisation and safe practice policy identifies that restraint is used as a last resort. The service currently has no residents on restraint or enablers.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

ARC D5.4e ARHSS D5.4e

**Attainment and Risk:** FA

**Evidence:**

The infection control programme has been reviewed. This is an improvement since the previous audit.

##### Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

#### 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:**

Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed to identify areas for improvement or corrective action requirements. Data, trends, corrective actions and quality improvements are discussed at management and staff meetings. Surveillance identified four residents with recurrent UTIs. One resident has not had a UTI for over six months. Infection control responsibilities are shared between the manager and administration person. Education on infection control is included in the orientation of staff. The manager/infection control co-ordinator has attended external training. Staff have not attended infection control education annually as per the education planner (link 1.2.7.5).

##### 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.)*