

Opunake Districts Rest Home Trust

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health Audit (NZ) Limited, an auditing agency designated under section 32 of 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).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Opunake Districts Rest Home Trust	
Premises audited:	Opunake Districts (The Cottage) Rest Home	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 19 February 2016	End date: 19 February 2016
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	20	

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

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

Indicator	Description	Definition
Yellow	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
Red	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

General overview of the audit

The Cottage Rest Home provides residential care for up to 22 rest home residents and occupancy was 20 during this audit. The governing body is the Opunake Districts Rest Home Trust, which is a community trust made up of six trustees from the local community.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the service's contract with the District Health Board (DHB). The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

Four of the seven areas identified as requiring improvement during the last audit have been addressed. The three remaining areas requiring improvement relate to medication documentation. Two new areas requiring improvement were identified during this audit. The improvements relate to management of food services and residents' care planning documentation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrate an understanding of residents' rights and obligations. Information regarding residents' rights, access to interpreter services and how to lodge a complaint is available to residents and their families. The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no investigations by external agencies since the last certification audit. The improvement identified during the last audit relating to the management of consent documentation has been addressed.

Organisational management

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.
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Opunake Districts Rest Home Trust (ODRHT) is the governing body and is responsible for the service provided at The Cottage Rest Home (The Cottage). A strategic plan was reviewed along with a philosophy, mission statement and business summary. The facility manager provides reports to the ODRHT which meets monthly.

The Cottage is managed by an experienced registered nurse. The facility manager is supported by a recently graduated registered nurse who works 54 hours a fortnight. Both registered nurses (RN's) have current annual practising certificates.

The service continues to make ongoing improvements with management of the quality and risk management systems. The two areas identified during the last audit as requiring improvement relating to quality and risk management documentation have been addressed. Clinical indicators are reported monthly to staff and the governing body. There is an internal audit programme and audits are completed. Risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, infection control surveillance, accident/incident forms, meeting minutes and surveys evidence analysis of data and the development of corrective action plans to address any issue/s that require improvement.

There are policies and procedures on human resource management. Staff files evidence job descriptions, orientation, performance appraisals, and police vetting. Current practising certificates are held on files for all health professionals who require them to practice.

An in-service education programme is provided for staff at least monthly. Caregivers are also supported to complete the New Zealand Qualifications Authority Unit Standards. The area requiring improvement during the last audit relating to completion of medicine competency has been partially addressed. Although all care staff have completed medicine management competency questionnaires, their practical competency has not been assessed.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The facility manager/registered nurse is available on call after hours. Care staff interviewed reported there is adequate staff available.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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All residents' files sighted provide evidence that needs, goals and outcomes are identified and reviewed on a regular basis, however interventions are not regularly updated to reflect assessment findings and this requires action. Residents and families interviewed reported being well informed and involved, and that the care provided is of a high standard.

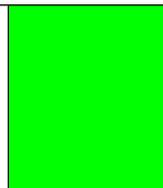
An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice; however practices sighted, and previously identified, are not always consistent with these documents and continue to require some input.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals. Some aspects of food storage and verification of cleaning practices require some attention.

Safe and appropriate environment

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.



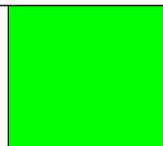
Standards applicable to this service fully attained.

The improvements required following the last audit relating to the use of personal protective clothing by staff have been made.

A current building warrant of fitness is displayed.

Restraint minimisation and safe practice

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.

Policy identifies that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. The care staff demonstrate knowledge and understanding of safe restraint management processes, including enabler use.

Infection prevention and control

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.

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. The results of surveillance are reported through all levels of the organisation, including governance.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	2	2	0	0
Criteria	0	36	0	1	4	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The improvements identified during the last audit relating to general consent documentation and advanced directives have been made.</p> <p>The informed consent policy guides staff in relation to informed consent. Resident files include documented consent relating to general consent. Consent is also obtained on an as-required basis, such as for influenza vaccinations. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are held at the facility where residents have named EPOAs; these were viewed on resident's files, where available.</p> <p>There was evidence of advance directives signed by the resident. Residents confirmed they are supported to make informed choices, and their consent is obtained and respected. Family members also reported they are kept informed about what is happening with their relative and consulted when treatment changes are being considered.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and</p>	FA	<p>The facility manager is responsible for the management of complaints. There are appropriate systems in place to manage the complaints processes. The last complaint documented in the complaints register was received in April 2014 (staff versus staff). The facility manager advised they do not receive complaints because they work hard to ensure any possible issues are dealt with before they have the chance to become a complaint.</p> <p>The facility manager advised there have been no investigations by the Ministry of Health, DHB, Health and</p>

upheld.		<p>Disability Commissioner, Accident Compensation Corporation (ACC), Coroner or Police since the previous certification audit.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Systems are in place that ensures residents and their families are advised on entry to the facility of the complaint processes. Residents and families demonstrated an understanding and awareness of these processes. Residents are able to raise any issues during the resident meetings. Residents and families interviewed and review of resident meeting minutes confirmed this. Review of the collated resident surveys for 2015 evidenced residents knew the process for making a complaint.</p> <p>The complaint process and forms were observed to be readily accessible and displayed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>A review of accident/incident forms showed timely and open communication with residents/family members. Communication with family members is recorded in the resident's file. Family members expressed satisfaction with how well they were kept informed about any change to the resident's condition and their involvement in resident care planning. Residents' meetings are held monthly and minutes were reviewed.</p> <p>The facility manager advised that interpreters are able to be accessed from: the district health board (DHB) interpreter services; the local community; or family members if required. This information is also provided to residents/families as part of the information/admission pack.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Opunake District Rest Home Trust is the governing body and is responsible for the service provided at The Cottage Rest Home (The Cottage). A strategic business plan was reviewed that includes a mission, vision and purpose. A quality improvement plan was also reviewed.</p> <p>Monitoring of the service provided at The Cottage includes regular monthly reporting by the facility manager to the trust. A sample of the facility manager's reports to the governing body were reviewed and include: reporting on quality and risk management issues; occupancy; human resource issues; and clinical indicators. Meeting minutes for the trust, staff/quality, and residents were also reviewed.</p> <p>The Cottage is managed by a registered nurse who was appointed in February 2010. The facility manager is supported by a registered nurse who works three days a week for up to 30 hours a week. The facility manager/registered nurse and the registered nurse's personal files and education records were reviewed and provide evidence of maintaining knowledge and current practice; both have current annual practising certificates.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p>

		<p>The Cottage is certified to provide 22 rest home level care and 20 of these beds were occupied during this audit. The service provider has funding contracts with the district health board (DHB) to provide aged related residential care (rest home), residential respite - rehabilitation support services, and long term support - chronic health conditions. The provider also has a contract with the Ministry of Health to provide residential - non aged; there is one resident aged less than 65 years of age. The Cottage also has a service agreement with the DHB to provide meals on wheels.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The two areas identified as requiring improvement during the last audit relating to quality and risk management systems have been addressed.</p> <p>A quality improvement plan is used to guide the quality programme and includes goals and objectives. An internal audit programme is in place and internal audits completed in 2015 were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures.</p> <p>Monthly staff/quality and resident meetings are held. Meeting minutes were reviewed and these are available for review by staff. Meeting minutes reviewed provided evidence of reporting/ feedback on completion of internal audits and various clinical indicators.</p> <p>The facility manager is responsible for ensuring the organisations quality and risk management systems are maintained. A staff member has recently been appointed to the position of quality/health and safety officer and they are responsible for completing and reporting internal audits to staff/quality meetings.</p> <p>Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed and reported. Quality improvement data reviewed, including adverse event forms, internal audits and meeting minutes provided evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant to the scope and complexity of the service and reference legislative requirements. Policies/procedures are available with systems in place for reviewing and updating the policies and procedures. Staff confirmed during interviews they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.</p> <p>Health & safety policies and procedures are available and staff are aware of and report hazards at the facility, when this is required. Chemical safety data sheets are available. Calibration of medical equipment is</p>

		conducted and recorded.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	FA	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the facility manager and the quality/health and safety officer and are signed off when completed. Corrective action plans to address areas requiring improvement are documented on accident/incident forms. The facility manager/registered nurse undertakes assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate (link criterion 1.3.6.1). The facility manager/registered nurse and care staff reported the facility manager/registered nurse is contacted if a resident has an unwitnessed fall when the facility manager/registered nurse or the registered nurse are not on duty.</p> <p>Staff confirmed they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they complete accident/incident forms for adverse events. Policy and procedures comply with essential notification reporting for example health and safety, human resources, infection control.</p> <p>The facility manager/registered nurse reported they are aware of their responsibilities concerning essential notifications and evidence of this was reviewed during audit.</p> <p>Resident's files reviewed as well as accident and incident forms, residents progress notes, and family communication sheets provided evidence that communication/contact with family is being documented following adverse events (as appropriate) involving the resident, or when there is any change in the resident's condition. Family members advised they are contacted if their family member has an accident/incident, and/or if there is any change in their condition. This finding was confirmed during review of the satisfaction surveys.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>The area requiring improvement during the last audit relating to completion of medicine competency has been partially addressed and improvements are still required.</p> <p>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checks, and police vetting and completed orientations. Current copies of annual practising certificates were reviewed for staff and contractors that require them to practice.</p> <p>The facility manager/registered nurse is responsible for management of the in-service education programme. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided. The facility manager/registered nurse and the registered nurse</p>

		<p>have the required interRAI assessments training and competencies.</p> <p>All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers.</p> <p>An appraisal schedule is in place and current staff appraisals were in the staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.</p> <p>Care staff confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided Sunday to Friday. The facility manager/registered nurse is on call after hours. The minimum amount of staff on duty is during the night and consists of two caregivers.</p> <p>Care staff interviewed reported there is adequate staff available and that they are able to get through their work. All staff have current first aid certificates. Residents and family interviewed reported staff provide them with adequate care.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management policy is comprehensive and identifies all aspects of medicine management.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines have completed a questionnaire to verify medication competence, however evidence of a practical assessment, as required by policy was not sighted (refer to criterion 1.2.7.5).</p> <p>Controlled drugs are stored in separate locked cupboard. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records.</p> <p>The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.</p>

		<p>The GP's signature and date are recorded on the commencement and discontinuation of medicines; however a previous request for the GP to sign and date medication charts at the three monthly reviews remains an ongoing request.</p> <p>Residents' who request to self-administer medicines have secure storage for their medicines and an initial assessment to verify safety and competency to administer, this partially addresses a previous corrective action requiring secure storage and an assessment of competency, however a policy requirement of ongoing assessment was not sighted.</p> <p>Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders are not used. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident's medication chart. PRN medication requests includes indications for use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is sighted.</p> <p>Most aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines, however attention is required when decanting dry products and verifying compliance with the sighted cleaning schedule.</p> <p>The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	<p>PA Moderate</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes, however in five of the seven files reviewed;</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>interventions were not updated to reflect recent assessment findings.</p> <p>Residents and family/whanau members expressed satisfaction with the care provided.</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>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.</p>	<p>FA</p>	<p>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.</p> <p>A residents' meeting is held monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan (refer 1.3.6.1)</p> <p>A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews, verified residents and family/whanau are included and informed of all changes</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are</p>	<p>FA</p>	<p>The improvements identified during the last audit relating to staff using personal protective clothing when handling soiled linen have been made.</p> <p>Material safety data sheets provided by the chemical representative are available and accessible for staff. Education on chemical safety was provided as part of the staff in-service education programme. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous</p>

<p>protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>substances.</p> <p>Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled are provided and being used by staff. For example, gloves, aprons and visors were sighted.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed that expires on 18 December 2016.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>In line with the Infection control standard of the Health and Disability Sector Standards(HDSS IC), monthly surveillance, of the required data for monitoring infection rates in rest homes is collected by the facility manager who is the IC prevention nurse. IC data is, collated each month and analysed to identify any significant trends or possible causative factors which are attended to. There have been no outbreaks since the last audit.</p> <p>Incidents of infections are presented to staff at handover and staff meetings, with any ongoing corrective actions discussed, as evidenced by meeting records, infection control records and staff interviews.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard (NZS 8134.2008). It states that the service aims to minimise the use of restraint and to ensure that if restraint is necessary, to keep the resident safe from harm from both themselves and others and that the practice occurs in a respectful manner. This includes the use of enablers which are voluntary and the least restrictive option to meet the needs of the resident. Staff interviewed verifies understanding of restraints and enablers and safe restraint use. On the day of audit one resident is using a restraint and one an enabler.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>Care staff have completed medication administration workbooks and these were reviewed on the personal files of care staff. None of the staff files reviewed had any evidence the practical competency of staff had been assessed as part of the competency assessment process. The facility manager/registered nurse confirmed this has not been done.</p> <p>Staff complete a medication administration error self-learning package if there is an error and these were reviewed on staff files.</p> <p>Medication management education is provided annually and was last provided by a pharmacist in May 2015 and is next scheduled for May 2016.</p> <p>Education planners for 2014, 2015 and 2016 were reviewed and education is provided at least monthly.</p>	<p>Care staff have completed medicine management competency questionnaires but their practical competency has not been assessed.</p>	<p>Provide evidence that all staff involved in medication management have had their practical competency assessed.</p> <p>30 days</p>

<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Moderate</p>	<p>Two of two residents who self-administer their medications, have an initial assessment verifying competency to administer their medicines, however a policy requirement for ongoing three monthly competency assessments are not sighted.</p>	<p>Residents, who desire to self-administer their medicines are not assisted to administer their medicines safely.</p>	<p>To facilitate the safe self administration of medicines.</p> <p>90 days</p>
<p>Criterion 1.3.12.6</p> <p>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.</p>	<p>PA Moderate</p>	<p>The GP's signature and date are recorded on the commencement and discontinuation of medicines; however the GP does not sign and date the medication chart to verify the medications are reviewed three monthly.</p>	<p>There is no evidence on medication charts that medications are reviewed three monthly.</p>	<p>Medication charts to be reviewed, signed and dated every three months by the GP.</p> <p>90 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>Most aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines, however dry food items in the pantry have been decanted and there's no evidence of use by dates. In addition there is no documentation to verify compliance with the cleaning regime.</p>	<p>Some aspects of food storage and preparation are not compliant with guidelines.</p>	<p>Aspects of food storage and preparation comply with guidelines.</p> <p>180 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Five of seven files reviewed had evidence of recent events that impacted on the care each of the residents required. This care was not documented in the care plan.</p>	<p>The interventions documented are not consistent with meeting the needs of the residents.</p>	<p>Interventions are consistent with meeting the residents assessed needs.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.