

# Chetty's Investment Limited

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Current Status: 5 November 2013

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

Alexander Lodge Rest Home is a 23 bed facility located in South Auckland and provides rest home level care. At the time of audit there are 19 residents receiving care. Four of the residents are aged under 65 years of age. The owner purchased this rest home in April 2013 and works on site. There have been no changes to the services, building or environment, with the exception of recarpeting and repainting the hallway and repairing the fence and retaining wall.

Monitoring of the quality and risk programme is overseen by an independent age care quality adviser. There is one registered nurse providing nursing services.

At the last audit there were two areas identified as requiring improvement. Both have been fully addressed. At this audit there are three areas identified as requiring improvement. This includes ensuring records demonstrate the recruitment policy is implemented; ensuring all applicable staff complete annual medication competencies; and ensuring information reported via the incident process is clearly linked with resident's individual care plans and evaluations.

## Audit Summary as at 5 November 2013

Standards have been assessed and summarised below:

### Key

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

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

### Consumer Rights as at 5 November 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 5 November 2013

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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### Continuum of Service Delivery as at 5 November 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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### Safe and Appropriate Environment as at 5 November 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### Restraint Minimisation and Safe Practice as at 5 November 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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### Infection Prevention and Control as at 5 November 2013

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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# HealthCERT Service Provider Audit Report (version 5.9)

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## Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of a health and disability service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## Audit Report

<b>Legal entity name:</b>	Chetty's Investment Limited
<b>Certificate name:</b>	Alexander Lodge Rest Home
<b>Designated Auditing Agency:</b>	DAA Group Ltd
<b>Types of audit:</b>	Unannounced Surveillance Audit
<b>Premises audited:</b>	5 Alexander Street, Otahuhu, Auckland
<b>Services audited:</b>	Rest home and Residential Disability Psychiatric
<b>Dates of audit:</b>	<b>Start date:</b> 5 November 2013 <b>End date:</b> 5 November 2013
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	18

## Audit Team

<b>Lead Auditor</b>	XXXXXX	<b>Hours on site</b>	8	<b>Hours off site</b>	4
<b>Other Auditors</b>	XXXXXX	<b>Total hours on site</b>	8	<b>Total hours off site</b>	4
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXXX			<b>Hours</b>	3

## Sample Totals

Total audit hours on site	16	Total audit hours off site	11	Total audit hours	27
Number of residents/patients interviewed	3	Number of staff interviewed	7	Number of managers interviewed	1
Number of residents'/patients' records reviewed	3	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	6	Total number of staff (headcount)	10	Number of relatives interviewed	1
Number of residents'/patients' records reviewed using tracer methodology	1			Number of GPs interviewed (Residential Disability providers only)	1

## Declaration

I, XXXXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Wednesday, 27 November 2013

## Executive Summary of Audit

### General Overview

Alexander Lodge Rest Home is a 23 bed facility located in South Auckland and provides rest home level care. At the time of audit there are 18 residents receiving care, and one boarder. Four of the residents are aged under 65 years of age. The owner purchased this rest home in April 2013 and works on site. There have been no changes to the services, building or environment, with the exception of recarpeting and repainting the hallway, and repairing the fence and retaining wall.

Monitoring of the quality and risk programme is overseen by an independent age care quality adviser. There is one registered nurse providing nursing services.

At the last audit there were two areas identified as requiring improvement. Both have been fully addressed. At this audit there are three areas identified as requiring improvement. This includes ensuring records demonstrate the recruitment policy is implemented; ensuring all applicable staff complete annual medication competencies; and ensuring information reported via the incident process is clearly linked with resident's individual careplans and evaluations.

### Outcome 1.1: Consumer Rights

The residents and families interviewed report that residents' rights are respected during service delivery. The residents' personal privacy is maintained and they are treated with dignity and respect. The residents, family, staff and the general practitioner interviewed have no concerns in relation to any forms of discrimination within the service. Information is provided on admission and is displayed. Staff demonstrate understanding of their obligations regarding residents' rights and how to incorporate this knowledge into their day-to-day practices and interactions with residents and family. The registered nurse and the general practitioner interviewed have a good understanding of open disclosure.

A complaints policy details how complaints are to be managed. Residents and the family member interviewed are aware of the complaints process. There have been no complaints received since the change of ownership.

### Outcome 1.2: Organisational Management

The owner purchased Alexander Lodge Rest Home in April 2013. The owner is new to aged residential care services and is supported by an experienced registered nurse. The Alexander Lodge business plan and future goals/aims, as well as the quality and risk plan, provide the framework for all services provided. The vision, mission and goals of the rest home are clearly documented.

The quality and risk programme includes complaints, incident and accident reporting, surveillance for residents with infections, audits, satisfaction surveys, policy/procedure review and risk/hazard identification and management. The quality and risk programme is facilitated by an independent aged care quality adviser (QA) who developed the programme and works on site at least one day a week. The QA also developed the systems and policies which are in use. The results of quality and risk activities are discussed with staff regularly at the monthly staff meetings and sooner where applicable. Corrective action planning occurs and is monitored for effectiveness. Whilst corrective action plans are developed following reported incidents, the information is not always included in individual resident's care plans or evaluation records and is an area requiring improvement.

Residents and family are included in all aspects of service planning and delivery. This is verified through interview with three residents and one family member. The organisation's policies have been updated to include all required aspects related to whanau involvement. The area identified as requiring improvement at the last audit now meets the standards.

There are documented procedures related to recruitment of staff and human resources processes. It is unable to be verified at audit that the recruitment policy is implemented, including interview and reference checking. This is an area requiring improvement. New staff complete an orientation programme. Staff participate in regular on-going education. Staffing numbers meets the requirements of the provider's contract with Counties Manukau District Health Board (CMDHB).

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

The registered nurse is experienced and ensures all residents are pre-assessed prior to admission by the needs assessment service co-ordinators or the mental health services team Counties Manukau District Health Board. A team approach to care delivery is encouraged and promoted at all times. No residents have been admitted under the Mental Health Act. Six of eighteen residents are under the mental health team.

A new activities co-ordinator has recently been employed. The activities programme is provided and enjoyed by the residents. Participation is encouraged, but is voluntary. Activities are chosen to be meaningful and the programme developed is implemented to ensure the interests of the residents are included. Outings in the community are arranged fortnightly in the rest home van and entertainers from the community are welcome to participate in the programme as well.

The medication management is safely implemented. A visual inspection of the medication system and the lunchtime medication round evidences compliance with legislative requirements. The pharmacy audits, inclusive of controlled drug management occurs six monthly and is conducted by the contracted pharmacist. The Medico medication system is utilised for this service and is managed well by the registered nurses. Six medication records reviewed have resident photograph identification. Audits are performed six monthly by the contracted pharmacist. There is evidence of the medications being reviewed by the pharmacist and stickers are used to evidence the packs have been packed and checked before being delivered to this service. The general practitioner's practice is in close proximity to this rest home. There is one area of required improvement in relation to medication competencies for the care staff which are not able to be evidenced as being current.

The service is managed by a cook who works three days a week, a relief cook who works three days, and the owner covers every Sunday. The menus are documented and displayed each day. The individual dietary needs and cultural needs of residents are met and dietitian input is clearly evident. Indian food is prepared specially for the Indian residents to meet their individual preferences. Meals are provided at appropriate times of the day. Special days are celebrated, such as, birthdays and festive occasions.

### **Outcome 1.4: Safe and Appropriate Environment**

There is a current building warrant of fitness which has an expiry of 9 February 2014. Processes are in place to ensure the ongoing requirements to maintain the building warrant of fitness are undertaken. Clinical equipment has performance monitoring undertaken by a contracted company. Hot water is tested monthly and is within the required range.

New carpet has been laid in the hallway and this area has also been re-painted. The carpet at the top of the stairwell has been refitted. The fence that was falling over at the last audit has been replaced along with the retaining wall. The areas identified as requiring improvement at the last audit now meet the

standards.

### Outcome 2: Restraint Minimisation and Safe Practice

The service has clearly described restraint minimisation and safe practice policies which comply with the standard. There is no restraint or enablers in use at the time of audit. Staff have received training on de-escalation techniques for managing challenging behaviours and education about the service policy, regulations and safe and effective alternatives to restraint. Staff interviewed understand that the use of enablers is a voluntary process along with approval and informed consent processes. Safety is promoted at all times.

### Outcome 3: Infection Prevention and Control

Surveillance for residents who develop infections is being undertaken. The surveillance programme is appropriate to the service. Results of surveillance are acted upon, evaluated and reported to the general practitioner, staff and the resident/whanua in a timely manner.

## Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	17	0	2	0	0	0
Criteria	0	47	0	1	2	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	38
Criteria	0	0	0	0	0	0	0	91

## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	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.	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 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.	PA Moderate	While incidents are being reported and corrective actions discussed during staff meetings and noted on the incident analysis summary, there is no clear linkage of the falls related incident data with the resident's six monthly evaluation of care in three of three files sampled. Of the three files sampled one resident had one fall in the preceding six month period, one resident had four falls in the preceding six month period and one resident had 10 falls in the preceding six month period. 2) Whilst falls prevention strategies are developed and discussed (including at staff meetings) some of the prevention strategies have not been linked to the resident's individual care plan. 3) Completed and analysed incident reports are not consistently filed in residents' files reviewed in variance to the organisation's policy.	Ensure there are clear linkages between reported events and individualised residents' evaluations and care plans. 2) Ensure the filing of completed incident reports complies with the organisation's policies.	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 1.2.7.3	The appointment of appropriate	PA Moderate	Records are not	Ensure records are available	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		service providers to safely meet the needs of consumers.		available to evidence the recruitment process for the two newest employees. Interview and reference checks are not present in the staff files. The owner is not available at audit to discuss/verify the recruitment process.	to verify that the organisation's recruitment policy has been implemented.	
HDS(C)S.2008	Criterion 1.3.12.3	Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Low	It is not able to be validated that all caregivers responsible for administering medications have completed the education and competencies required.	To ensure all caregivers responsible for medication management are competent to do so.	180

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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## Outcome 1.1: Consumer Rights

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

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

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

**Attainment and Risk:**FA

**Evidence:**

Policy fully describes that open disclosure is part of everyday practice. The policy fully defines the key principles of open disclosure inclusive of openness and timeliness. Also the recognition of the reasonable expectations of the residents and their support person are acknowledged. The registered nurse supports the staff. All staff interviewed, inclusive of the registered nurse and four of four care staff, understand the principles of maintaining confidentiality. Residents have the right to full and frank information and open disclosure from staff. The registered nurse and the general practitioner interviewed understand about open disclosure and providing appropriate information when required. The use of interpreter services is identified in policy and is readily available when required. The Code is displayed and the registered nurse explains and discusses rights of the resident with the resident and the family on admission as required. This is also addressed at the residents' meetings held three monthly. Education is provided for all staff as per the education records sighted.

The ARRC requirements are met.

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

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

**Attainment and Risk:**FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:**FA

**Evidence:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>There is a complaints policy (February 2013). It notes the resident's right to make complaints. It refers to major and minor complaints. Minor complaints are complaints that can be dealt with immediately. The policy notes the frequency of on-going communications with the complainant if the complaint cannot be resolved within 10 working days of receipt of the complaint.</p> <p>Three of three residents and one family member confirms they are aware of the complaints process and have no complaints.</p> <p>Two healthcare assistants (HCAs) are interviewed. Both are aware of how they are to manage and report complaints should a complaint be received. The HCAs advise they are not aware of any complaints being received since the change of ownership of the rest home. From time to time a resident or family member may express a concern about an aspect of care, the environment or a resident's need. The HCAs provided an example about a resident wanting a different meal choice or wanting bed linen changed. The two staff advise that where residents make any requests, they work to facilitate these quickly, wherever possible, rather than leave things unsorted that might then later result in a complaint. The two HCAs report that they advise the RN and/or owner manager of what the concerns are, and how the concern has been addressed. The registered nurse advises there have been no complaints since the change of ownership, including from the Ministry of Health (MOH), Health and Disability Commissioner (HDC) or District Health Board (DHB) or since the last audit.</p> <p>The requirements of the ARRC contract are met.</p>

**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.

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

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The business, quality and risk plan is dated as reviewed in September 2013. It notes Alexander Lodge Rest Home came under the ownership of Chetty's Investment Ltd in April 2013.
<b>MISSION STATEMENT:</b> To provide a quality, homely environment in which the frail elderly and/or confused elderly may live in an atmosphere of respect and friendliness and have their physical and psychological needs met regardless of culture, race or creed.

## PHILOSOPHY :

- assist all residents to maintain their independence and involvement in making decisions affecting their lives to the highest level possible for each individual.
  - encourage each resident and their family/whanau to be involved in the planning and provision of care.
  - encourage a high level of wellness by maintaining a caring and stimulating environment.
  - encourage residents to maintain outside contacts with family/whanau, friends, church and other relevant groups.
  - facilitate mixing with other residents and joining in activities.
  - encourage all residents to maintain links with cultural or spiritual organisations, friends and family and ensure staff are knowledgeable and sensitive to the values and beliefs which are important to the resident. This will be reflected in training.
  - ensure consultation acknowledges cultural differences.
- The policy notes it is the responsibility of all staff to deliver a service to the residents that meet all requirements, standards and best practice guidelines.

This scope of the service is residential care facility with 23 beds.

The introduction/company history notes 'we provide a homelike and safe environment for each resident and assist the residents social, spiritual, cultural and recreation needs'.

The registered nurse (RN) advises the internal audit programme, complaints programme, resident meetings and reported events (incidents) are used to monitor how the organisation is progressing to meet the organisation's values, mission and goals.

The owner is an engineer and his curriculum vitae (sighted at a previous audit) shows he has worked in this industry in NZ for over 23 years. The owner manager has attended more than eight hours of education on relevant aspects of care and managing an aged care facility since April 2013 (purchasing the business) and certificates of attendance are sighted. The owner is working in the resthome on a day to day basis. The RN and contracted quality adviser identifies the owner is responsible for all human resources activities, maintenance/gardening, developing the roster, paying staff wages, accounts receivable and payable and undertakes some of the internal audits. The manager also undertakes some of the communications with family members and often takes residents to appointments with health professionals off site. There is a documented list which details the manager's activities (sighted). The owner is unable to be interviewed as is on urgent leave at the time of audit. The external quality facilitator (that was contracted by the previous owner) has continued in a contracted role and is on site at least one day each week. The quality adviser came on site and is interviewed during the audit.

The good employer / staffing policy (January 2013) notes 'the manager will be available during office hours and on call 24 hours a day'. The manager holds a current qualification or has experience relevant to both management and the health and personal care of older people, and is able to show evidence of maintaining at least 8 hours annually of professional development activities related to the aged care sector'. The role of the Manager is described in the policy and includes ensuring the residents are adequately cared for in respect of their everyday needs, and that services provided to residents are consistent with obligations under legislation and the terms of their admission agreement.

A registered nurse is employed. She has worked in Alexander Lodge Rest Home (ALRH) for over two and a half years and worked for the previous owner. She has experience in the aged care industry having been employed as the clinical manager in two previous facilities. The RN also works shifts at ADHB and holds a current RN level three professional development and recognition portfolio (which is sighted). There had previously been two RNs working ten hours each per week until three weeks prior to this audit when the other RN resigned. The remaining RN advises she is now working 16-20 hours per

week and is responsible for ensuring the clinical / care needs of the residents are being met. The RN is participating in relevant ongoing education and records sighted verify this.

The requirements of the Age Related Residential Care contract (ARRC) contract are met.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### 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.

#### Attainment and Risk:FA

##### Evidence:

The organisation's business, quality, risk and management plan (September 2013) identifies a focus on continuous quality improvement.

The programme includes ensuring:

- policies and precedures are up to date
- staff are appropriately trained
- ensuring culturally appropriate care is provided
- internal audits are used to review processes and provide early detection of problems
- all infections be reported and evaluated
- incidents and accidents are reported and evaluated with an improvement focus
- not using restraints
- seeking resident and family involvement in care
- risk management process are identified in the quality and risk plan (September 2013).

There is a quality and risk plan (September 2013) which notes goals and objectives, management controls and who is responsible. This document details the process/cycle to be used for corrective action planning.

There is a list of goals and ambitions for 2013. This includes 20 items including (facility renovations and maintainence, staff training, equipment purchase, updgrading the call bells and installing closed circuit security monitoring in public areas).All except six have been achieved as at the time of audit.

The 'control of documents and records' (August 2013) document and 'document flow chart' (August 2013) includes the requirements for how policies and procedures are to be documented and managed. Formal authorisation of documentation is identified on the system index that identifies and authorises all current documentation issue. The system comprises ten quality manuals. These policies and procedures have been developed by an external consultant and emailed to the owner/manager. The quality and risk advisor (who is also the author of the policies) states the documents are reviewed and localised to reflect Alexander Lodge Rest Home. All policy manuals sighted during audit evidence that policies are being regularly reviewed. The quality consultant advises she is currently responsible for updating/localising the policies to ALRH and archiving previous documents. Folders containing obsolete policies are sighted at audit. Copies of all resident related forms are retained in the nurses' station in a folder (sighted).All amendments to policies and procedures are recorded on review and amendment log (sighted in the front of manuals reviewed). Two of two health care assistants (HCAs) interviewed advise they are notified of changes in policies and procedures by either the owner, quality and risk advisor or a RN. Discussions on changes are also occur during staff meetings and this is confirmed by staff during interview.

Regular (curently monthly) staff meetings provide a forum for discussing quality issues. This is attended by the owner, RN and quality consultant. All staff are invited and if they cannot attend they are required to read and sign the meeting minutes. This process is verified to occur at audit for the three sets of meeting minutes sighted. Minutes of meetings are maintained and a template agenda is used. Minutes sighted dated 15 July 2013, 5 August 2013, and 2 September 2013, demonstrate discussion on relevant quality and risk activities, including complaints (nil received from residents/family), and reported incidents (inlcuding resident falls, a wandering resident, skin tear, bruising, medication error and episodes of challenging behaviour). Resident infections, use of restraint (nil), audit results, training/education, general issues, hazards and risk identification and individual resident care needs are also discussed.

Two of two HCAs interviewed confirm there is regular ongoing feedback on quality and risk issues. Where necessary, this occurs at handover or one on one with staff. The two HCAs advise a full discussion and summary of all reported events occurs at the monthly staff meeting which is attended by the external quality facilitator.

A folder is maintained which contains copies of completed internal audits. There is an internal audit calendar for 2013. There are templates used to record data specific to each individual audit. Audits selected and reviewed related to:

- staff files (October 2013): There are 13 areas included in the audit. The results note there are files missing job descriptions, current appraisals, job descriptions and reference checks. The RN has obtained some of the documentation but this remains a work in progress.
- staff satisfaction survey (October 2013): Completed staff responses sighted. This audit has yet to be analysed.
- medication records: (August 2013): A review of each residents medication records occurred. The audit identified a number of areas requiring improvement which are clearly identified. This includes missing signing sheets, staff sample signatures, absence of stop dates for some antibiotic courses, resident identification data and requiring updated photo are included in the issues. All discrepancies are sighted to have been addressed within nine days. The results of the audit are discussed at the staff meeting in September 2013.
- non restraint environment audit (October 2013): Notes no restraints or enablers in use and staff aware of the organisation's policies
- the Code of Rights audit (October 2013): Notes substantially compliant with requirements. All residents are reported to be happy with no complaints
- privacy of information audit (18 August 2013): Note compliance with all audit requirements. Records are kept private, appropriately archived and secure.
- cleaning audit (29 April 2013): High level of compliance noted. Area for improvement related to removing dead flowers from resident rooms and needing appropriate storage for the mops. A corrective action plan is developed.
- resident file check (26 August 2013): three resident files reviewed. Some components are not in order. Plan documented and discussed with staff at staff meeting.

The quality adviser states a resident satisfaction survey is scheduled for December 2013.

There is a summary register maintained for the corrective actions arising from audits. There are three issues which remain open and are on the agenda for the next staff meeting. There is evidence of evaluation and follow-up of issues. An area requiring improvement is raised in 1.2.3.4 to ensure evaluation of reported events and required interventions are also included in individualised resident's records.

A residents meetings was held in May 2013. This is attended by 17 residents. The meeting minutes reflect discussion on activities, food, overall satisfaction with services and general discussion points. The minutes summarise six components to be discussed with staff. These are sighted to have been discussed with staff at the staff meeting on 10 June 2013.

The risk management programme includes identification of risks, objectives and management controls and who is responsible and how the risk will be

measured. The level of risk is related to current controls. The quality and risk programme sighted includes a range of resident related risks, environmental risks, certification and compliance risks, pandemic related risks, accident and incident related risks, loss of key staff, succession planning and natural disasters (sighted) and loss of documentation / electronic data. Fraud / theft, natural disasters and personal grievance are also noted as risks factors. The owner manager advises she reviews this at least annually or sooner if required. The quality adviser and the RN confirm they are working together to manage the components of the quality and risk programme with the involvement of the manager.

There is a hazard register which has been recently reviewed.

The ARRC contract requirements are met.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

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

**Corrective Action:**

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

**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.

**Attainment and Risk:**PA Low

**Evidence:**

The accident and incident reporting policy (April 2011) notes 'Alexander Lodge Rest Home aim to offer an incident free environment for residents, staff and visitors within our powers and complying with the Health and Safety Act 1992. All adverse, unplanned or untoward events are systematically recorded, investigated and analysed and appropriately statutory agencies are notified of essential information by the manager'.

An accident is defined as anything that makes a resident unhealthy or unhappy or when personal injury occurs (ie, skin tears, infections, falls, fractures). Any incidence of abuse and/or neglect, or where any event occurs which creates risk or potential harm or injury, are to be reported to enable management to quickly identify areas where incidents are happening, to instigate corrective action in order to prevent re-occurrence. It is the responsibility of each person to report all incidents and accidents occurring in their area of responsibility as soon as practicable, within the rostered shift on which the incident/accident occurred.

Incidents are being reported, analysed and discussed at staff meetings. While corrective action plans are developed (and implemented) these are not always linked with the individual resident's care plans. Evaluations in all three residents' files reviewed in detail does not include evaluations of reported events, including falls. The completed incident reports are not consistently files in residents' files. These are areas requiring improvement.

The adverse event /exception reporting (non-conforming) document (December 2010) is reviewed. The manager (or delegated person) is responsible to report events requiring essential notification. This includes:

- the Health and Disability Services (Safety) Act to the Director General of Health
- serious accidents that have or may put at risk the health and safety of people for who services are provided
- any police investigation related to the services provided
- any death of a person that is required to be reported to a coroner under the Coroner's Act. There is a template form which details these and other essential notifications.
- Department of public health needs to be notified on infection matters.

The quality adviser states there has been one essential notification to the MOH and DHB mental health services since the last audit.

#### **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:**PA Moderate

**Evidence:**

There is a template form staff are required to document incidents on. Two of two HCAs interviewed are able to identify the type of events that are required

to be reported via the incident / accident reporting process. The HCAs confirm they are provided with information related to incidents involving residents either individually by the owner manager or RN or via the shift handover process. Overall feedback from the owner and quality and risk advisor in relation to the number, types and themes of reported events occurs via the staff meeting.

A review of the incident summary register identifies the following:

June 2013= two reported events

July 2013 = six reported events

August 2013 = six reported events

September 2013 = four reported events

October 2013 = data is currently being collated

The reported events includes medication error, bruising, a skin tear, falls, and a resident wandered off site. One resident is noted to have frequent falls and has since been assessed as requiring hospital level care and has moved to another facility. The policy notes the incident reports are to be filed in the resident's notes following analysis. A review of three residents' files identifies at least eleven of the incident reports as detailed on the master register have not been filed in the resident's notes in variance to requirements.

While there is evidence of discussion and corrective action planning at staff meetings and corrective action plans are noted on the incident analysis forms; not all interventions (especially related to falls prevention) are being included in the individual resident's care plan. The number of events are also not being analysed and included in individual resident's six monthly care evaluations in the three of three residents' files where this is reviewed and is an area requiring improvement.

Six incident reports selected at random for 2013 year are reviewed. Evidence of open disclosure is present in the notes and/or is documented on the incident report. The one family member interviewed verifies that staff keep the family fully informed in a timely manner of changes in health and other events.

**Finding:**

While incidents are being reported and corrective actions discussed during staff meetings and noted on the incident analysis summary, there is no clear linkage of the falls related incident data with the resident's six monthly evaluation of care in three of three files sampled. Of the three files sampled one resident had one fall in the preceding six month period, one resident had four falls in the preceding six month period and one resident had 10 falls in the preceding six month period. 2) Whilst falls prevention strategies are developed and discussed (including at staff meetings) some of the prevention strategies have not been linked to the resident's individual care plan. 3) Completed and analysed incident reports are not consistently filed in residents' files reviewed in variance to the organisation's policy.

**Corrective Action:**

Ensure there are clear linkages between reported events and individualised residents' evaluations and care plans. 2) Ensure the filing of completed incident reports complies with the organisation's policies.

**Timeframe (days):**90(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

## Standard 1.2.6: Family/Whānau Participation (HDS(C)S.2008:1.2.6)

Family/Whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.

**Attainment and Risk:**FA

**Evidence:**

The family participation policy has been updated and now includes all required components to meet this standard. The family member interviewed confirms being both consulted and kept informed in a timely manner of the resident's care needs. The RN and two of two HCAs interviewed can describe how family/whānau is involved in the provision of care. The area identified as requiring improvement at the last audit now meets the standard.

### Criterion 1.2.6.3 (HDS(C)S.2008:1.2.6.3)

The service has policies and procedures related to family/whānau participation. The policies and procedures are used to maximise family/whānau involvement in the service and ensures their feedback is sought on the collective view.

**Attainment and Risk:**FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:**PA Low

**Evidence:**

Policies and procedures provide guidance on human resources and recruitment processes. There is monitoring of staff and contractor annual practising certificate (APCs). Current APCs are sighted for the RN, general practitioner (GP), podiatrist and pharmacist.

Reference checks and interview records are present in three of five staff files reviewed. These checks are missing from the two newest employee files. Verifying implementation of the recruitment processes cannot be verified at audit and the owner cannot be interviewed as is on urgent unplanned leave. This is an area requiring improvement.

Staff are required to complete an orientation programme. This is documented and includes an orientation to the facility, policies and procedures, responsibilities, individual residents and their care needs and emergency procedures, Records are sighted verifying staff (including the two newest employees) are completing/have completed

orientation requirements.

Staff are provided with ongoing education. This occurs at least monthly as a component of the staff meeting. The in-service topics are advertised for staff in advance and these are sighted. The two HCAs advise the education is informative and relevant for their roles. Records of provided education sighted includes (but is not limited to):

- April 2013 : Advance care planning – attended by five staff
- April 2013 : Falls prevention – attended by seven staff
- June 2013 : Fire evacuation procedures – attended by six staff
- June 2013: Code of Rights, privacy, advocacy and confidentiality – attended by seven staff
- July 2013- Infection prevention and control – attended by five staff
- August 2013: First aid and medication management – attended by eight staff
- September 2013: Health and safety, security, civil defence emergencies; restraint minimisation and managing challenging behaviours – attended by five staff
- October 2013 : Health and safety and security – attended by four staff.

### **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:**PA Moderate

**Evidence:**

A review of five staff files occurred at audit. Reference checks and interview records are present for three of the five staff. Reference checks and interview records are missing from the two newest employees' files. The owner is away on the day of audit and so is unable to be interviewed on the recruitment process. Verifying implementation of the recruitment process is an area requiring improvement.

**Finding:**

Records are not available to evidence the recruitment process for the two newest employees. Interview and reference checks are not present in the staff files. The

owner is not available at audit to discuss/verify the recruitment process.

**Corrective Action:**

Ensure records are available to verify that the organisation's recruitment policy has been implemented.

**Timeframe (days):**90(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

**Attainment and Risk:**FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:**FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:**FA

**Evidence:**

The good employer policy, which includes staffing and skill mix (January 2013), notes it is the manager's (or delegated persons) responsibility that staffing is appropriate in safe and workable numbers, to ensure care and services delivered to all residents is at an excellent standard. Junior staff will be rostered to work with senior staff. The ARRC contract requirements are specified. The policy details the responsibilities of the registered nurse as per the ARRC contract.

At audit there is a template repeating roster which two HCAs advise is changed if a staff member is on leave/away. If a staff member is unable to work their shift for any reason, two of two caregivers and the RN advise that another staff member fills in.

The current roster sighted at audit is dated 23 September 2013 onwards and includes the following:

- the RN is rostered on duty Monday to Friday and reports to spread her hours throughout the week. The RN is on call when not on site.
- the owner is rostered on site weekdays and is on call when not on site.
- there are designated hours each day allocated for the cook
- there are four hours allocated in the afternoon seven days a week for activities
- there is at least one HCA on duty at all times. There is an additional HCA on duty between 8am and 12 pm and 4 pm to 8 pm.
- The HCAs undertake the cleaning and laundry duties.

There is always a staff member on duty with a current first aid certificate.  
The requirements of the ARCC contract are met.

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

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

**Attainment and Risk:**FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.3: Continuum of Service Delivery

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

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

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

**Attainment and Risk:**FA

**Evidence:**

There are policies and procedures in place to identify how residents receive timely, competent and appropriate services to meet their needs as identified in the assessment processes. The initial care plan is documented within twenty four hours of admission taking into consideration the needs assessment service co-ordinators (NASC) assessment prior to admission. Three of three resident files were sighted. The registered nurse works sixteen to twenty hours each week and stands in for the manager when absent. The long term care plan is developed within three weeks of admission. The three of three care plans reviewed have been reviewed six monthly or more frequently if and when required. There is clear evidence and involvement of the consultation sought with the residents, the multidisciplinary team, in particular the mental health team, resident's family/whanau and/or advocate. The one family member interviewed verified that they are always invited to participate in the evaluations.

Handover is provided between all shifts. The care staff work twelve hour shifts to promote continuity of care and a team approach. This is encouraged at every opportunity and verified in the three of three residents' records sighted. The staffing is adequate for this rest home and this is reflected in the roster reviewed. The registered nurse interviewed stated that additional staff can be arranged if and when required. The four of four care staff interviewed, the cook and the activities co-ordinator interviewed stated that the staffing (workforce) is stable.

Each stage of service delivery is undertaken by the suitably skilled staff. The annual practising certificate for the one registered nurse was available and sighted. There is an education programme for staff that covers the essential components of the service and service delivery provided. The three of three care plans sighted are maintained in the working folder electronically and a copy is retained in the individual resident's records. The general practitioner is readily available and visits regularly and is on call seven days per week twenty four hours a day. The mental health crisis team for Counties Manukau District Health Board (CMDHB) is available for assistance twenty four hours a day. The mental health community residential care nurse visiting the facility stated that there is always support offered after hours. The consumer and their respective family members with consent of the resident are provided with all relevant information and updates on the health and well-being of the individual resident. The mental health community nurse ensures the resident and staff are educated about the individual resident's diagnosis so that there is a good understanding. The mental health community nurse documents a care plan sighted and a preventative relapse plan at the same time promoting wellness and optimal quality of life for the resident concerned.

The ARRC requirements are met.

Tracer Methodology: Rest home

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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

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

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.3.3.5 (HDS(C)S.2008:1.3.3.5)**

The service provides information about the consumer's physical and mental health and well-being to the consumer, their family/whānau of choice where appropriate, and other services it has links with.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.3.3.6 (HDS(C)S.2008:1.3.3.6)**

The service works to reduce as far as possible the impact and distress of ongoing mental illness, and provides or facilitates access to information, education, and programmes for consumers and family/whānau, to reduce psychiatric disability, prevent relapse, promote wellness and optimal quality of life for the consumer.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

**Attainment and Risk:**FA

**Evidence:**

Resident care planning is put in place from the findings of the assessment process. The initial care plan must be in place within twenty four hours of the resident's admission. The three of three care plans reviewed have a standardised format that is individualised to the resident's assessed needs. The record of the one resident has an appropriate long term care plan that clearly identifies the individual resident's needs and care requirements. The resident has two care plans one developed by the mental health team key worker and one developed by the registered nurse. The general practitioner is able to contact the mental health team key worker anytime for a resident to be reviewed or for advice. Three monthly psychiatrist visits can be arranged for a resident on a referral basis only. The four of four care staff interviewed report they receive adequate information to assist with maintaining continuity of care for each resident.

The ARRC requirements are met.

### Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

**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 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

**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 1.3.5.4 (HDS(C)S.2008:1.3.5.4)**

The service delivery plan identifies early warning signs and relapse prevention. The plan is developed in partnership with the consumer, the service provider, and family/whānau if 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.

**Attainment and Risk:**FA

**Evidence:**

Short term care plans are used for problems that can be resolved within four weeks. The three of three long term care plans reviewed record interventions that are consistent with the residents` assessed needs and desired goals. The family is notified if there is any changes to the care plan and this is recorded in the progress records. Observations on the day of the audit indicate that residents are receiving the care that is appropriate and consistent with the individual resident`s needs. All three of three and one family member interviewed report that the service meets the needs of the resident. The registered nurse interviewed reports that the care plans are up to date and do reflect the individual needs of the resident and care staff members are able to follow the plans easily. The residents under the mental health team are monitored closely by the visiting mental health community team nurse who ensures the resident`s under the team receive the least restrictive care and management and support as required. A resident for example had ordered her own taxi to go shopping in the morning of the audit and safely returned after lunch. The staff interviewed both clinical and non-clinical have a good understanding of respect, acceptance and promoting mental health well-being for the individual residents at this rest home

The ARRC requirements are met.

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.3.6.3 (HDS(C)S.2008:1.3.6.3)**

The consumer receives the least restrictive and intrusive treatment and/or support possible.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### Criterion 1.3.6.5 (HDS(C)S.2008:1.3.6.5)

The consumer receives services which:

- (a) Promote mental health and well-being;
- (b) Limit as far as possible the onset of mental illness or mental health issues;
- (c) Provide information about mental illness and mental health issues, including prevention of these;
- (d) Promote acceptance and inclusion;
- (e) Reduce stigma and discrimination.

This shall be achieved by working collaboratively with consumers, family/whānau of choice if appropriate, health, justice and social services, and other community groups.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The previous activities co-ordinator resigned early in October 2013. The newly appointed activities co-ordinator interviewed has only been in this position for two weeks working 8am to 1pm as a caregiver and 1pm to 4pm as the activities co-ordinator. The programme reviewed is developed for the rest of this year and includes gardening, movies, 'happy hour' (non-alcoholic), van outings two weekly into the community and exercise to music and music sessions. The activities co-ordinator has a current drivers licence and the manager also drives the van when required. Copies of the licences are retained by the manager. Recently the residents went on a trip to the Auckland Botanical Gardens. Celebrating the different cultures is popular; the Indian festival of lights was recently celebrated with active participation from the residents. Two residents attend community care on a regular basis and get picked up and are brought back to the rest home daily. Three of three activities plans are available and are up-to-date appropriately. Staff interviewed also assist and join in with the activities with the residents. Staff often take a resident for a walk along the street or up to the shopping centre near-by.</p> <p>The ARRC requirements are met.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Policy identifies that care plans are evaluated if there is a change in the resident's condition and that they are reviewed six monthly or more often if required. A team approach is considered for the six monthly reviews. Interventions are changed if the needs change to ensure the goals set can be effectively met. All evaluations are recorded by the registered nurse with the date or changes made.</p> <p>If a resident is not responding to the service interventions being delivered, or their health status changes, then this is discussed by the registered nurse with the general practitioner. The general practitioner validated this information. Short term care plans are developed and implemented as required, for example, for wound care management, infections, changes in mobility and changes in food or fluid intake; pressure area care is also a reason if an individual resident is at risk or their skin integrity is poor. These processes are clearly documented on the short term care plan, medical and nursing assessments and in the residents' progress records. If progress is different than expected information is provided to the family. The general practitioner interviewed stated that he is able to speak with family members during his visits to the rest home or arrangements can be made for family to see the GP at the surgery/medical practice. The mental health community nurse evaluates the mental health care and relapse plans on a regular basis especially if any changes have occurred for the individual resident concerned. The GP is able to consult with the psychiatrist at CMDHB at any time if he is concerned about a resident under the mental health team.</p> <p>The ARRC requirements are met.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)**

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> From a mental health perspective the twenty four hour crisis mental health team is available. Six of eighteen residents are currently under the mental health team from CMDHB. Key mental health team workers are available during normal working hours. There are copies of referral letters and/or discharge letters in the three records sighted. Residents can be provided with options if required to access other health and disability services. There is only the one general practitioner responsible for the

residents in this rest home although residents are able to retain their own GP if they wish. The GP can arrange a referral to specialist services when it is necessary. The GP interviewed reports that referral services at CMDHB respond to referrals quite promptly. Transportation can be arranged to take residents to an appointment if family are unable to take them. Transition, exit, discharge or transfer are all covered in policies and procedures reviewed. If a resident's health status changes the GP is notified by the registered nurse. If a resident requires a higher level of care, being hospital level or specialised dementia care, a referral letter is sent to the NASC service for a re-assessment to be completed and authorised. If a resident is to be transferred to CMDHB Middlemore Hospital the GP contacts the service required or alternatively the GP contact number is available to arrange the admission. The registered nurse or care staff on duty arrange the transportation and complete the required DHB transfer yellow envelope information required. The resident register is maintained and a record noted in the individual resident's record of the transfer and/or admission.

The ARRC requirements are met.

### Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

**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.

**Attainment and Risk:**FA

**Evidence:**

There is a detailed medicine management policy that is reflective of current safe practice and meets legislative requirements. The lunchtime medication round was observed. The senior care giver administering the medication is very experienced and has been in this role for ten years. The standing orders have been reviewed by the GP and signed off by the GP appropriately 10 October 2013. All medication records have been reviewed three monthly by the GP. Any special directions for administering medication is documented by the contracted pharmacist in red. Allergies and sensitivities, if any, are clearly documented by the pharmacist. Information is obtained by the registered nurse when the resident is admitted and information is provided to the pharmacist. The pharmacist's annual practising certificate is available and has been sighted by management and a record is maintained. The Medico medication system is utilised for this service to promote safety and is working effectively for this service. The pharmacist applies a sticker on each individual medication pack to verify the date the pack is packed and checked. The medications are stored in a locked cupboard in the medication room. The medications are re-checked by staff when the packs arrive from the pharmacy. There is one area of required improvement for 1.3.12.3 in relation to senior care givers competencies for medication administration not being current and up to date. There are no residents that are self-administering medication

and this is service policy, especially for the mental health residents. The key worker or the mental health community residential care nurse ensures any new medication is discussed with the GP, the resident concerned and their family/whanau representative.

The ARRC requirements are met.

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

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

**Attainment and Risk:**FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:**PA Low

**Evidence:**

The education records for medication training has been reviewed but not all information is available on caregiver competencies.

**Finding:**

It is not able to be validated that all caregivers responsible for administering medications have completed the education and competencies required.

**Corrective Action:**

To ensure all caregivers responsible for medication management are competent to do so.

**Timeframe (days):**180*(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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**Criterion 1.3.12.7 (HDS(C)S.2008:1.3.12.7)**

Continuity of treatment and support is promoted by ensuring the views of the consumer, their family/whānau of choice where appropriate and other relevant service providers, for example GPs, are considered and documented prior to administration of new medicines and any other medical interventions.

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

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The menu plans sighted are three weekly. Winter and summer menus are available. Currently the summer menus are now being implemented. There is evidence of dietitian review occurring and a letter dated 06 June 2012 is available. The plans are displayed on the white board in the dining room on a daily basis. A birthday list is available for all residents in the kitchen. The cook prepares a cake for these special days for the resident concerned and this is shared by all residents for afternoon tea. The cook interviewed explained how the roster sighted covers this service seven days a week. There are two cooks who cover three days each and the manager covers every Sunday presently. Cleaning schedules are available for kitchen duties over and above the cooking. The cook has recently redone the first aid training and a first aid box is available in the kitchen which is accessible.</p> <p>Fridge monitoring occurs and the cook maintains the records accurately. The food is ordered by the cook interviewed and the manager purchases the supplies as required. All food is purchased locally and or delivered to this service. All food is stored appropriately and prepared within appropriate areas in the kitchen. All kitchen staff have completed hand hygiene and safe food management certificates. Food is prepared separately for the Indian residents at this rest home and they are served first, before the other residents, which is culturally appropriate. Residents have made their own placemats during activities and these are kept on the table during the day for all meals.</p> <p>The ARRC requirements are met.</p>

**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.

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

**Corrective Action:**

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

**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.

**Attainment and Risk:**FA

**Evidence:**

There is a current building warrant of fitness which has an expiry of 9 February 2014. Processes are in place to ensure the ongoing requirements to maintain the building warrant of fitness are undertaken. Clinical equipment has performance monitoring undertaken by a contracted company. Hot water in four patient areas is tested monthly. Records for July to October 2013 verify the water is within the required range. Monitoring maintenance of the lift is occurring and records are sighted.

New carpet has been laid in the hallway. This area has also been painted. The carpet at the top of the stairwell has had the wrinkles removed and the risk of falls removed. The fence that was falling over at the last audit has been replaced along with the retaining wall. The areas identified as requiring improvement at the last audit now meets the standards.

ARRC contract requirements are met for the criterion audited.

### Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:**FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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### Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The service has a clearly described restraint minimisation and safe practice policies and procedures which comply with the standard. There is no evidence of restraint or enablers in use at the time of the audit. Staff have received training in de-escalation techniques for managing challenging behaviour and education about the service policy, regulations and safe and effective alternatives to restraint. Staff interviewed understand that the use of enablers is a voluntary process along with approval and informed consent processes. Safety is promoted at all times.

#### **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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>Surveillance frequency and type is set out in the surveillance policy and determined by the organisation`s infection control policies and procedures that are reflective of the services offered at the rest home. Surveillance is appropriate to the size and complexity of the facility and includes urinary tract infections, skin infections, upper and lower lung chest infection, multi-drug resistant organisms, scabies and influenza like illnesses. Residents with suspected infections are reported to the RN and documentation is completed. Infection control data is collated by the RN and presented monthly to staff via staff meetings.</p> <p>The infection surveillance data sighted for July 2013 (one resident infection), August 2013 (five resident infections) and September 2013 (four resident infections). There is analysis of the number and type of infections and comparison with the preceding month period. Details of treatment provided and outcomes are noted.</p> <p>The minutes of the staff meetings sighted for July 2013, August 2013 and September 2013 evidence discussion on the infection rates, likely contributing factors and prevention strategies. The meeting in July 2013 included training for staff on how to observe, report and prevent wound infections, urinary infections and chest infections. Signs and symptoms of infections are discussed and the importance of good hand hygiene noted.</p>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>