

Matamata Country Lodge Limited

Current Status: 18 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

Matamata Country Lodge is a 74 bed facility offering rest home and hospital level care. Since the last audit the service have converted two apartments to provide an additional four rest home beds. The service had 12 areas of required improvement identified at the last certification audit, with all of these now addressed. There are no new areas of improvement required identified at this unannounced surveillance audit.

Audit Summary as at 18 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
	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 18 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 18 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.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 18 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 18 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 18 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 18 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 Aged Residential Care Audit Report (version 3.91)

Introduction

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

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

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

Audit Report

Legal entity name:	Matamata Country Lodge Limited
Certificate name:	Matamata Country Lodge

Designated Auditing Agency:	DAA Group
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Types of audit:	Surveillance Audit
Premises audited:	20 Elizabeth Street, Matamata
Services audited:	Rest home and hospital level of care
Dates of audit:	Start date: 18 November 2013 End date: 18 November 2013

Proposed changes to current services (if any):
The service has converted two apartments to provide four additional rest home beds. A Ministry of Health letter dated 8 October 2012 states a verification audit is not required and to include reference to the new facilities in their next routine audit.

Total beds occupied across all premises included in the audit on the first day of the audit:	70
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Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	4
Other Auditors	XXXXX	Total hours on site	8	Total hours off site	4
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	16	Total audit hours off site	10	Total audit hours	26
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Number of residents interviewed	8	Number of staff interviewed	9	Number of managers interviewed	2
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	2
Number of medication records reviewed	12	Total number of staff (headcount)	80	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	

Declaration

I, XXXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the 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 Monday, 9 December 2013

Executive Summary of Audit

General Overview
Matamata Country Lodge is a 74 bed facility offering rest home and hospital level care. Since the last audit the service have converted two apartments to provide an additional four rest home beds. The service had 12 areas of required improvement identified at the last certification audit, with all of these now addressed. There are no new areas of improvement required identified at this unannounced surveillance audit.

Outcome 1.1: Consumer Rights
Communication is provided in an open and honest manner that reflects the services open disclosure policy. There are policies and procedures for access of interpreting services as required.
Complaints are managed to meet policy requirements. At the time of audit the service has no outstanding complaints.
The previous area for improvement relating to cultural identity being evidenced on care plan assessment has been addressed.

Outcome 1.2: Organisational Management
The facility is part of the Cantabria Group of aged care services. The management ensure that services are planned and co-ordinated to meet residents' needs. The organisation's business plans identifies their purpose, values, priorities and goals. Planning processes are reviewed annually and evaluated quarterly to measure achievement. Any deficits in service delivery are managed through corrective action planning.
The day to day operation of the facility is undertaken by staff who are appropriately experienced and qualified to undertake the role in a manner that ensures residents' needs are being met in a safe and efficient manner.
All quality and risk management processes are implemented to meet policy requirements. Policies and procedures reflect current accepted good practice. Incidents, accidents and untoward events are recorded, evaluated and discussed with family/whanau in a manner that is reflective of open disclosure principles. All quality actions are recorded and reported at staff and management level. Key components of service are explicitly linked to quality management systems. Quality data collection and findings are used as opportunities for improvement which are well documented. Quality improvements are evaluated to ensure the desired outcomes are reached. Management of risk is undertaken to a level beyond that normally expected and a 'continuous improvement rating' is attained. The previous area for improvement to ensure corrective action plans addressing all areas requiring improvement are consistently developed, implemented and monitored for effectiveness, is now addressed and an area of improvement implemented since the last audit.

Staffing levels and skill mix are maintained to meet recommendations and contractual requirements. The previous area for improvement to ensure there is documented evidence that staff performance appraisals are consistently occurring is now addressed and an area of improvement implemented since the last audit.

Outcome 1.3: Continuum of Service Delivery

The residents and family interviewed express a high level of satisfaction with all aspects of service delivery. Services are provided by suitably qualified and experienced staff in both the rest home and hospital. The service meets the contractual time frames in the assessment, planning, review and evaluation of the residents' needs. The provision of services meets the individual needs of the residents. The care plans that are developed are based on the assessed needs of the resident. The previous area for improvement has been addressed. Rest home residents, who have increased care needs, are reassessed to hospital care as required. Four rest home residents have recently been reassessed for hospital level care.

A safe and timely medicine management system is observed at the time of audit. Medicines are managed by staff who are assessed as competent to perform the role. All medicine legislative requirements are met. The previous area for improvement has been addressed.

The activities programme is overseen by a qualified diversional therapist within the group who visits monthly to assist the two activities coordinators. The activities programme provides varied options and activities are enjoyed by the residents. Community activities are encouraged, outings are arranged on a regular basis and family/whanau are welcome to join in with these activities. Residents and family/whanau are satisfied with the activities programme in place.

Matamata Country Lodge uses a four weekly menu cycle approved by a dietitian. Initial dietary assessments identify special dietary requirements. All food preparation and storage is safe and meets legislative requirements. All kitchen staff, except two new employees, have food handling certificates. The two new employees are to attend the next course available.

Outcome 1.4: Safe and Appropriate Environment

The facility has a current warrant of fitness. The service has converted two apartments to provide a four additional rest home beds since the last audit. These rooms provide adequate space to provide rest home level of care. The Service's previous areas for improvement to ensure electrical safety checks or calibration of equipment is completed, is now addressed. The service has a documented and implemented process to ensure the drinking water tank is maintained to ensure the water is suitable for drinking. This is an area of improvement implemented since the last audit.

Outcome 2: Restraint Minimisation and Safe Practice

The service has no residents requiring enabler use and five residents assessed as requiring restraint (bed rails and lap belt). Where enablers are used, these are voluntary and the least restrictive option for the resident. Staff are able to demonstrate their understanding of the restraint minimisation policy and procedures and the definition of an enabler. The previous areas for improvement to ensure all staff have a restraint competency and ensuring the review of restraint occurs in line with the organisation's time frames are now addressed and improvements implemented since the last audit.

Outcome 3: Infection Prevention and Control

Evidence is seen if surveillance of infections. The two previous areas for improvement have been addressed.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	21	0	0	0	0	0
Criteria	0	43	0	0	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	29
Criteria	0	0	0	0	0	0	0	58

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Attainment and Risk: FA

Evidence:

Evidence is seen in six files reviewed(two hospital and four rest home) of resident's cultural identity being recorded in assessment and planning documentation. The previous area for improvement is completed.

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

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

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

Attainment and Risk: FA

Evidence:

The service undertakes communication with residents and family in an open and honest manner. The three of three family/whanau interviewed confirm they are kept informed of the resident's status, including any events adversely affecting the resident. The resident, and where appropriate family, are invited to attend the multidisciplinary team (MDT) review. Evidence of open disclosure is documented in the family contact sheets, on the accident/incident form and in the residents' progress notes (evidenced in six of six residents' files).

The service has an interpreter policy, which documents how to contact an interpreter. The nurse manager states that there are no current residents who require an interpreting service.

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:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Complaints management is explained as part of the admission process. It is fully described in policy and shown in the resident welcome book. The manager includes the right to complain as part of the admission discussion and the service respects the resident's right to make a complaint. The sighted complaints procedure is easily accessible, responsive and complies with Right 10 of the Code.

The complaints register for 2013 is sighted. All complaints show in detail the corrective actions taken, by whom and that they have been resolved to the complainant's satisfaction. The complaints register also records if the complaint is required to be linked to the risk management plan. A sample of two complaints in May 2013 confirms the time frames in Right 10 of the Code are met.

Interviews with eight of eight residents and three of three family/whanau confirm their understanding of the right to make a complaint.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA
Evidence: The overall mission statement of the organisation is 'love, care, dignity and quality of life'. The organisation's purpose, scope direction and goals are reviewed as part of the annual business plan. The business plan for 2013 was reviewed in March 2013. The plan covers the Cantabria Group of rest homes, hospitals and retirement villages. The business plan documents the direction of the day to day running of each of the facilities to the nurse managers. The nurse managers provide a monthly report to the organisational management and advisory boards. The nurse manager is a registered nurse (RN) with a current practising certificate (sighted). The nurse manager has over 20 years' experience in the age

care sector and has worked at this service for over 10 years. The nurse manager has been in the current management role since 2008. The nurse manager position description describes the accountability and responsibilities for the management of Matamata Country Lodge. The nurse manager has attended in excess of 8 hours education related to age care management in the past 12 months. The nurse manager has completed the interRAI training. The nurse manager reports the services are managed to meet the needs of the rest home and hospital level of care residents.

The manager is supported by the group manager for Cantabria Group of aged care services and the organisation's management and advisory boards.

ARRC requirements are met

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The previous CAR at 1.2.3.8 was made to ensure action plans addressing all areas requiring improvements are consistently developed, implemented and monitored for effectiveness, and is now addressed and an area of improvement implemented since the last audit.

The two RNs, three caregivers, and the two members of the management team can verbalize their knowledge and understanding of the quality and risk processes that are identified in policy. Documentation sighted confirms policies and procedures are fully implemented. Hazard management is undertaken as part of everyday processes. All policies and procedures sighted are current. Policies and procedures are developed by the Cantabria Group's quality group and reviewed at least two yearly. New and revised policies are presented to the quality group for approval. Each policy's footer contains the documented version control. Obsolete documents are archived, with only the most recent version available for staff.

The service has a documented internal auditing system that covers the key components of service. The internal audits sampled for 2013 (staff files, infection control, resident files) record any non-compliances and the corrective actions if any shortfalls are identified. The back of each of the internal audits sighted contains documentation of the corrective action required, who is responsible, date completed, and outcomes. The form also records when the issues are discussed with staff members, if the actions taken improved service and the sign off by the nurse manager. The five of five clinical staff (three caregivers and two RNs) confirm any issues are discussed at staff meetings, through communication folders and verbally as required. The quality improvement data collected is analysed, evaluated, and trended by the manager and the RN. If a trend is noted to be increasing then corrective action planning is put in place as required. Corrective actions are put in place for any deficit that is noted during internal or external audits and in response to complaints, resident requests and satisfaction survey result findings as appropriate.

The staff meeting has a standing agenda of health and safety, emergency services, infection control, feedback from internal audits, quality improvement plans, orientation and training, complaints and any other areas that the staff wish to discuss. The monthly quality and risk management report to the management board covers health and safety, infection control, restraint, complaints, event reports, medication errors, wounds and financial issues.

Actual and potential risks are identified, documented and communicated to staff and residents as appropriate. The system used by the service identifies all hazards and if they cannot be eliminated, they are added to the significant hazard register. Hazards are reviewed and evaluated quarterly at the management level and reported against at the annual service review meeting. Safe operating procedures are shown for all identified hazards.

ARRC requirements are met.

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

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

Attainment and Risk: FA

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The previous CAR at 1.2.4.3 was made to ensure there is consistency in the completing of the incident forms to ensure shortfalls identified with corrective actions are put in place, is now addressed, and an area of improvement implemented since the last audit. Six of six incident forms sighted all document the corrective actions taken.

The three caregivers interviewed understand their obligations of when they are required to complete an incident/accident form.

The adverse event reporting system is used to make improvements to services as required. The individual resident accident/incident form records any short falls and the corrective actions that are implemented (confirmed in six accident/incident forms sighted). The adverse events are also reported and evaluated at the monthly occupational safety and health (OHS) meeting and also reported as part of the manager's report to the board. Each of the issues identified are discussed at the OSH meeting, with the follow up actions documented (confirmed in minutes sighted). The monthly OHS staff feedback report covers any hazards that are identified.

The ARRC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Previous CAR at 1.2.7.3 to ensure there is documented evidence that staff performance appraisals are constantly occurring annually is now addressed and an area of improvement implemented since the last audit.

There is a system in place to record annual practising certificates (APCs) for staff that require them. A copy of the APC and scope of practice are kept onsite, with the manager having a folder of the current APCs and a register of when they are due. Current APCs are sighted for the RNs, GPs, podiatrist, pharmacy and physiotherapy.

A review of six staff files (three RNs, two caregivers and one cook) and staff interviews confirm that the orientation process prepares staff for the roles they undertake. The orientation covers manual handling, 'buddy shifts', an orientation checklist, fire policy questionnaire, medication policy questionnaire and practicum (for relevant nursing staff), OSH questionnaire and a six week appraisal. The service also has a competency assessment register for fire, infection control, OSH, hoist transfers, medications (including insulin), restraint minimisation and safe practice and wound care. The registered nursing staff have access to the clinical leadership development programme through the DHB.

The review of six staff files and reviews of the training records sighted for 2013 identifies that the service plans, facilitates and records all education. Education is undertaken onsite and offsite and is presented by specialist providers as is appropriate. The service conducts the in-service education weekly (confirmed at interview with the three of three caregivers). The organisation is committed to staff education and staff are paid to attend the compulsory education. The service offers the Aged Care Education (ACE) programme to the care staff that do not have a national qualification. The service maintains attendance records for the education programme, both on the individual staff member's record and the attendance sheet for the education session. The in-service education programme sighted covers the requirements for aged care services.

The relevant ARRC requirements are met.

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service utilises the aged care safe staffing guidelines as a basis for the rostering and staff skill mix. The staffing levels consider the layout of the service and staffing is provided for the hospital, rest home and assisted living complex (rest home level of care). There is at least one RN on duty at all times in the hospital level of care. The service has a clinical nurse leader (RN) in charge of the hospital. (RN) on duty Mondays to Fridays. There is a clinical nurse leader for the rest home sections on duty four days a week and a staff development nurse on duty at least one day a week.

The hospital section (maximum 21 residents) has four caregivers on duty for the morning and afternoon shifts and one caregiver on night shift. The rest home wing (18 residents) has two caregivers on morning and afternoon shift and one caregiver on night shift. The assisted living complex (rest home level of care) has five caregivers on morning shift, three caregivers on afternoon shift and two caregivers at night.

There are two activities staff, with planned activities staff rostered for six days a week. There are adequate kitchen, cleaning and laundry staff to meet the needs of the residents. There are staff designated to the retirement village chalets/units that is additional to the staff of the rest home and hospital sections of Matamata Country Lodge.

The eight of eight residents and three of three family/whanau report that the residents receive a good quality of care.

The ARRC requirements are met.

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

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

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA
Evidence: Service delivery documentation is overseen by the Clinical Leader (CL) in the rest home and the Charge Nurse (CN) in the hospital. In the six files reviewed (four rest home and two hospital) there is evidence of initial assessment, care plans being completed and clinical risk tools being reviewed in the required timeframes. Matamata Country Lodge is in the process of using interRAI for clinical documentation (cover sheet, assessment and care plan). The care plan is personalised, reviewed and amended within required timeframes. The clinical risk assessments and follow up times for documentation reviews are all completed. The CL and CN report there is a process for annual multidisciplinary resident reviews, or as required. There is evidence in the six files reviewed (four rest home and two hospital), that the family/whanau are invited to attend and sign the meeting notes following the meeting. Handover at the beginning of each shift is undertaken in the nurses' station for privacy, in both the hospital and rest home nurses station. Matamata

Country Lodge have the services of four GP's who visit as required or the resident is taken to the clinic, if able. Coverage is also available by one of the four doctors at all times. The five clinical staff report (two RNs, three caregivers) that they are given information concerning service delivery at handover and any other time if there is a change in service delivery requirements.

The TL and CN report that the Mental Health Services for the Older Person (MHSOP) from the WDHB visits as required for challenging behaviour assessment (evidence sighted).

The three relatives interviewed are very positive about the staff, GP and all aspects of care. The five clinical staff interviewed (two RNs and three caregivers) report that they are kept up to date with all clinical changes.

Tracer Methodology Hospital:

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

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.

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

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

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

Attainment and Risk: FA
Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

In six of the six files reviewed (four hospital and two rest home) there is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are assessed at required timeframes to ensure resident's desired outcomes are being met. The NM and the GM (Group Manager) report that if a rest home resident requires assessment for hospital level care a referral is made to WDHB. The TL and CN report on interview that Disability Support Limited is involved and evidence is seen of documentation. Consideration is required for each re-assessment of bed availability and the type of care required. There is evidence of four rest home residents being re-assessed and approved for hospital level care. The NM reports verbally on this process and evidence is seen of rest home residents with acute care needs having short term care plans completed. If the change becomes a long term issue a referral is made for re-assessment. There is evidence that rest home residents are re-assessed for hospital level care as required.

The five clinical staff (three caregivers /two RN) interviewed report they are informed of any care plan changes at hand over and have relevant in-service

education as required.

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

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

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

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Attainment and Risk: FA
Evidence: <p>There are two activities coordinators, who work 30 and 37 hours each, employed at Matamata Country Lodge. The group diversional therapist visits monthly to oversee the activity plan and documentation. The planned activities reflect ordinary patterns of life and take into consideration the assessed needs of residents.</p> <p>Neither of the activity coordinator staff are available for interview but the NM reports that it is important to have activities at similar times each day as the residents get in to a routine. This includes morning walks and exercises. She reinforces that physical activities are best in the morning as this is the residents' 'alert times' and just before lunch she has a sing a long to stimulate appetites for lunch. External visits include museums, tour of gardens and a horse stud.</p> <p>The three relatives and eight residents (six rest home and two hospital) report on interview the activities are positive and include walking, singing, knitting and bowls.</p> <p>The NM reports that equipment is available for care staff when they are not on duty and during the weekend.</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.

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

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

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

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA
Evidence: In six of the six files reviewed (four hospital and two rest home) evidence is seen of documentation if an event occurs that is different from expected and requires changes to service. Individual short term care plans are seen for wound care, infections and challenging behaviours. These are kept in the resident's folder and each shift a staff member documents in the progress notes. These are transferred to the long term care plan if required. Long-term care plans are reviewed every six months or earlier as required. Evidence of this was sighted in six of the six files reviewed. Evidence is seen of the family/whanau involvement in the care reviews. The three relatives report that they receive invitations to the multidisciplinary meeting. The evaluations reflect the achievement and progress towards meeting the desired outcomes. The previous area for improvement has been addressed. The five clinical staff (three caregivers and two RN) interviewed have knowledge of the care plan documentation requirements.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

Attainment and Risk: FA

Evidence:

Matamata Country Lodge uses the blister pack medicine system whereby medicines are delivered monthly except for PRN medication which are delivered as required. When the medicines are delivered they are checked by the RN for the first 24 hours of dispensing. There are controlled drugs in the in the hospital. All processes comply with the legislative requirements.

There is evidence in all twelve medication charts reviewed (eight rest home and four hospital) of three monthly reviews by the GP.

There are no standing orders in place.

Evidence is seen of a process of stock being returned to the pharmacy when it is out of date or not required. The RN reports that the GPs work with the pharmacy but they are responsible for all medicines administered to their residents. If medicine is brought in by family this is approved by the GP and he charts on the medication sheet. There was no GPs available on the day of the audit.

The RN in the hospital or competent caregiver are responsible for medication rounds. Evidence is seen of the designated staff having up to date competency for medicine management and administering medicines. The RN observed during the lunchtime medicines round followed correct procedures.

There is one rest home resident undertaking self-administration of medicines at Matamata Country Lodge. Documented evidence is compliant with requirements and a locked drawer is provided in the resident's room.

Medicine sheets are signed in ink as required following administration.

Evidence is seen of individual medicines being discussed with the family at the multidisciplinary meeting.

Fridge temperatures for storing medicines are recorded and evidence is seen of this. The previous area for improvement has been addressed.

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA

Evidence:

Matamata Country Lodge uses a four week menu cycle. Evidence is seen of a qualified dietitian review and implementation of the changes recommended.

An individual dietary assessment is completed on admission which identifies individual needs and preferences. This is carried out in consultation with the family/ whanau as required. Morning and afternoon teas are prepared in the kitchen and there are sandwiches available over 24 hours. The Care Planning policy identifies that the food, fluid and nutritional needs of the resident will be provided in line with recognised nutritional guidelines that are appropriate to the resident's assessed requirements.

Food transport trolleys are used to transport the food to dining rooms in the hospital and rest home. A third dining room is served direct from the kitchen. Evidence is seen of recording of temperatures of meals as required. Staff attend food safety courses. The last was in 2011 and evidence is seen of a booking for next year for new staff.

In six of the six files reviewed, there is evidence of initial dietary assessment identifying specific needs and the kitchen is notified accordingly. This can include vegetarian diets, diabetic diets or cultural requirements.

The lunch time meal was observed on the day of the audit and residents spoken to are happy with the meals provided. Policy identifies that additional or modified nutritional requirements or special diets are part of the care planning process. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the GP, notifying the kitchen of extra dietary requirements and changes to care plans. The cook reports that she is always made aware by the TL or the CN of any specific dietary requirements for residents. There are lists on the white board in the kitchen which identifies special dietary needs, likes and dislikes.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: The previous CAR at 1.4.2.1 made to ensure all applicable equipment evidences the required electrical safety checks or calibration is now addressed and an area of improvement since the last audit. The current warrant of fitness expires on 1 December 2013. The maintenance worker reports the inspection check for the next building warrant of fitness

has already been conducted. Electrical safety checks are last conducted 1 November 2013 (sighted test and tag labels). Biomedical equipment performance verification report sighted for blood glucose meters, electric bed, weigh scales, sphygmomanometers and thermometer undertaken on August 2013.

Since the last audit the service has converted two apartments to provide an additional four rest home beds, these rooms number 2, 2A, 39 and 40 (sighted) provide adequate spaced and privacy for all occupants in these rooms. These rooms are single occupancy, have ensuites and call bells installed. The rooms provide adequate space for the resident and any mobility aids. The rooms have at least one large window for natural light and ventilation, with two of the rooms having sliding doors that lead to a veranda or court yard. Two of the residents interviewed who live in these rooms report satisfaction with these rooms.

ARRC requirements are met

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.)

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

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

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

Attainment and Risk: FA
Evidence: The previous CAR at 1.4.7.4 was made to ensure the service documents and implements a process to ensure the water tank is suitably maintained to ensure the water is suitable for drinking, is now addressed and an improvement implemented since the last audit. The water tank has a filtration system to maintain the water in a drinkable condition. The maintenance worker reports that the water tank also has a generator to operate the filtration system if there is a power shortage. The water tank has an accessible tap to access for emergency use for grey water and potable water. The service has emergency lighting, food and civil defence supplies in the event of an emergency.

Since the last audit, the service has converted two apartments to rest home level of care. This change of use has not required a change to the evacuation scheme.

The ARRC requirements are met.

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The service has no residents requiring enabler use at the time of audit, as confirmed at interview with the restraint coordinator and clinical staff. The service defines enabler use as voluntary and the least restrictive option to meet the needs of the resident. The three of three caregivers interviewed demonstrate understanding that enablers are voluntary and the least restrictive option.
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Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

The previous CAR at 2.2.3.6 was made to ensure each service provider who deals with restraint has an individual record of competency in relation to restraint minimisation and safe practice, is now addressed and an improvement implemented since the last audit. The register for restraint competencies evidences all care staff have a competency in relation to restraint minimisation and safe practice for 2013. The three of three caregivers report that they have a current restraint competency. The staff files of the five clinical staff (three RNs and two caregivers) evidence a current competency in relation to restraint minimisation and safe practice.

The ARRC requirements are met.

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

The previous CAR at 2.2.5.1 was made to ensure organisational time frames are met for the regular review of restraint practice. This is now addressed and an improvement implemented since the last audit. The last reviews are conducted in April 2013 and October 2013 as sighted in the internal audit schedule. Restraint use is also reported to the managers in a monthly report. The reports evidence that the service is progressing towards the minimising the use of restraint and currently five residents in the hospital sections are assessed for restraint use. These restraints are bed rails and a lap belt. The internal audits record that the service is compliant with the restraint minimisation and safe practice policies and procedures. The quality review of the restraints include all points in criteria 2.2.5.1 (last conducted October 2013).

The ARRC requirements are met.

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

Attainment and Risk: FA

Evidence:

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

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

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Attainment and Risk: FA
Evidence: The previous area for improvement relating to the policy not including renovation and construction has been addressed (CAR 3.3.2). Evidence sighted. All policies and procedures reflect current good practice and are suitable for the service provided.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

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

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

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

Attainment and Risk: FA

Evidence:

An annual summary of the number and type of infections per month is maintained and sighted for 2012. A register is kept of all residents who develop infections, the type of infections, results of cultures (where obtained) and details of treatment provided. The register notes whether further follow-up is required.

A form is completed for each infection by the RN and the laboratory provides evidence of any organisms grown. The Cantabria group benchmarks data against each other. Staff are informed each month at staff meetings of infections. The staff report on interview that they are given education on all aspects of infection control and surveillance issues.

An outbreak of vomiting and diarrhoea in January 2013 was managed using correct guidelines; evidence is seen of this is the 'outbreak book'.

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Attainment and Risk: FA

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