

G J & J M Bellaney Limited

Current Status: 12 November 2013

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Verification 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

Wimbledon Villa currently provides dementia care for up to 27 residents. At the time of the audit there were 23 residents. This audit has assessed a new wing as suitable to provide care for 18 residents with dementia. The new wing incorporates part of an existing wing. As a result the existing wing will decrease from 27 beds to 19 beds.

The service has undergone a change in management structure since the previous certification audit. There is a clinical facility manager who works from Tuesday to Saturday and has 30 years of aged care and psychiatric nursing experience. She also has experience as a manager in aged residential care. She has been a registered nurse at Wimbledon Villa since April 2012 and clinical manager since July 2013. She is supported by an administrative facility manager who has a management and business background and has been a manager at the facility since September 2010.

Improvements are required to the medication management system, staff training around dementia standards, completing the kitchenette, having a process to keep meals hot in the new wing, wall surfaces being painted, installing the purchased curtains and blinds, installing carpets and vinyl on the floors, having appropriate furniture, installing hand rails in halls and bathrooms, securing the internal door from the existing unit and external door, completing the hot water system so temperatures can be monitored, the courtyard being completed, bathrooms and toilets being completed, increasing the capacity in the laundry and having a folding area, having sufficient stored water and having the call bell system operational.

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:	GJ & JM Bellaney Limited
Certificate name:	Wimbledon Villa
Designated Auditing Agency:	Health and Disability Auditing New Zealand
Types of audit:	Partial Provisional
Premises audited:	Wimbledon Villa, 204 Manchester Street, Fielding
Services audited:	Dementia specific care
Dates of audit:	Start date: 12 November 2013 End date: 12 November 2013
Proposed changes to current services (if any):	
The service plans to add a new, separate 18 bed dementia wing. As part of an existing wing is included in the new wing the existing 27 bed unit will drop to 19 beds.	
Total beds occupied across all premises included in the audit on the first day of the audit:	23

Audit Team

Lead Auditor	XXXXX	Hours on site	5	Hours off site	4
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXX			Hours	1

Sample Totals

Total audit hours on site	5	Total audit hours off site	5	Total audit hours	10
Number of residents interviewed		Number of staff interviewed	2	Number of managers interviewed	2
Number of residents' records reviewed	3	Number of staff records reviewed	5	Total number of managers (headcount)	2
Number of medication records reviewed	13	Total number of staff (headcount)	21	Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology				Number of GPs interviewed	

Declaration

I, XXXXX, Director of Christchurch 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	Not Applicable
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 Friday, 6 December 2013

Executive Summary of Audit

General Overview

Wimbledon Villa currently provides dementia care for up to 27 residents. At the time of the audit there were 23 residents. This audit has assessed a new wing as suitable to provide care for 18 residents with dementia. The new wing incorporates part of an existing wing. As a result the existing wing will decrease from 27 beds to 19 beds.

The service has undergone a change in management structure since the previous certification audit. There is a clinical facility manager who works from Tuesday to Saturday and has 30 years of aged care and psychiatric nursing experience. She also has experience as a manager in aged residential care. She has been a registered nurse at Wimbledon Villa since April 2012 and clinical manager since July 2013. She is supported by an administrative facility manager who has a management and business background and has been a manager at the facility since September 2010.

Improvements are required to the medication management system, staff training around dementia standards, completing the kitchenette, having a process to keep meals hot in the new wing, wall surfaces being painted, window coverings, floor coverings, having appropriate furniture, hand rails, securing the unit, hot water temperatures, the courtyard being completed, bathrooms and toilets being completed, increasing the capacity in the laundry and having a folding area, having sufficient stored water and having the call bell system operational.

Outcome 1.1: Consumer Rights

Outcome 1.2: Organisational Management

The mission statement is 'committed to providing quality residential care in a homely, safe and caring environment giving consideration to the residents' physical, mental, social and spiritual well-being and respecting their dignity'.

The current business plan includes goals and strategic direction including the plan to expand the unit with the new wing. Performance is monitored through an internal audit programme.

During a temporary absence of the clinical facility manager, the service is managed by the registered nurse who has been at Wimbledon since April 2013 and has a strong mental health background including psychogeriatric care.

There is a human resources policy that establishes the requirements for vetting of qualifications and the maintenance of practising certificates for registered nursing staff. Relevant checks are completed to validate individual qualifications and experience. A record of practising certificates is maintained for two registered nurses and other health professionals including the pharmacist, GP's and the dietitian.

Wimbledon Villa has in place job descriptions for all positions. There is a total of 21 permanent staff. Human resources policies are in place. A comprehensive orientation programme is in place that includes the assessment of initial competencies. There is an improvement required around staff completing the required dementia standards.

The staffing and skill mix policy includes a section on staffing levels rationale and is based on Ministry of Health guidelines. It is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of residents. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for the rest home residents.

The roster is planned to be graduated as residents increase.

The service intends to provide a full day orientation day for new staff prior to the opening of the new unit that will include (at a minimum) challenging behaviour management, infection control, a fire drill, medication management, food and fluid management, incident reporting, safety and security and other relevant material.

Outcome 1.3: Continuum of Service Delivery

Three resident files were sampled and all contain a current falls assessment, pain assessment, pressure risk assessment, nutritional assessment, continence assessment and acuity assessment. Care plans reviewed show that in all three five files all identified areas of need are included in the care plan. The three files sampled included three residents with challenging behaviour, one with diabetes and one with previous weight loss. Care plans clearly outlined all appropriate interventions including detailed behaviour management techniques, management of hyper and hypoglycaemia for the resident with diabetes and interventions that have resulted in the resident previously losing weight now having gained weight for several months consecutively. This shortfall has now been addressed.

The medication management system includes the medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: Safe Management of Medicines. The medication is in a locked room. Medication is administered from a medication trolley by competent caregivers and registered nurses. There are a number of improvements required around medication management.

There are food service policies in place and the kitchen staff have all attended food handling training and a food safety course. The kitchen contains appropriate cooking and storage equipment. There is a preparation area and receiving area. Diets are modified as required. Residents are encouraged to be as independent as possible and each has a rehabilitation plan in place to encourage further development of skills and quality of life.

An improvement is required to developing a system to transport food that is hot to resident rooms and completing the kitchenette in the new unit.

Outcome 1.4: Safe and Appropriate Environment

The new wing consists of an open plan lounge/dining area with a smaller lounge partially divided. There are 18 single rooms in a square format around a courtyard. The rooms are suitable in size and six rooms have external doors onto the courtyard. The courtyard is 10 metres by 11 metres and has not yet been finished or landscaped. This requires addressing prior to occupation. The owner reports a dementia provider in Sydney will be providing advice on the landscaping of the courtyard. The format of the wing is such that residents can wander in a circular format throughout the building or across the courtyard.

The new wing consists of an open plan lounge/dining area with a smaller lounge partially divided. There are 18 single rooms in a square format around a courtyard. The rooms are suitable in size and six rooms have external doors onto the courtyard. The courtyard is 10 metres by 11 metres and has not yet been finished or landscaped. This requires addressing prior to occupation. The owner reports a dementia provider in Sydney will be providing advice on the landscaping of the courtyard. The format of the wing is such that residents can wander in a circular format throughout the building or across the courtyard.

The unit is not yet secure, either on outside doors or from the existing unit. The unit has eight rooms with ensuite bathrooms and two shared bathrooms able to cater for residents with moderate to high needs.

There is a staff toilet and visitor's toilet in the existing unit.

Cleaning and laundry services are well monitored throughout the internal auditing system - last audit in October 2013. All linen is laundered off site and only personal washing is completed in the small domestic size laundry that has one commercial washing machine and one commercial drier. Laundry (for personal items) is completed by caregivers. The laundry is situated in the existing Courtyard wing. Six monthly fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment.

Fire training and security situations are part of orientation of new staff.

Emergency equipment is available at the facility. Civil emergency boxes sighted. First aid training has been provided for staff.

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Two of five caregivers have been at the service longer than one year and have not yet completed the required NZQA dementia standards.	Ensure all staff complete the required NZQA dementia standards within the required contractual timeframes.	180
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	One of 13 medication files sampled does not have allergies documented. (ii) Ten of 13 medications charts sampled have some PRN medications that do not document indications for use. (iii) One of 13 medication charts sampled has not had all medications signed for by the prescribing doctor.(iv) Five of 13 medication charts sampled have not been reviewed by the doctor three monthly. (v) Seven of 13 medication charts	Ensure allergies are documented. (ii) Ensure PRN medication prescriptions document indications for use. (iii) Ensure all medication charts are signed. (iv) Ensure all medications are reviewed by the GP at least three monthly. (v) Ensure medications are administered as prescribed.	7

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				sampled have regular medications that have not been signed as administered.		
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low			
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	The service has not yet purchased a system to keep meals hot when they are being served in the new unit. (ii) The kitchenette in the new wing where residents will be provided with tea and coffee from is not yet complete.	Purchase a suitable system to keep meals hot while they are being served to residents in the new wing. (ii) Complete the kitchenette in the new wing.	Prior to occupancy
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Moderate	Wall surfaces are not yet finished. (ii) Window coverings have not yet been fitted. (iii) Floor coverings have not yet been fitted. (iv) Furniture is not yet available. (v) Hand rails have not yet been installed. (vi) The unit is not yet secure. (vii) Hot water temperatures cannot yet be monitored; (viii) The building has not yet been completed and therefore the CPU is not fully signed off.	Ensure wall surfaces are painted. (ii) Ensure window coverings are installed. (iii) Ensure floor coverings are fitted) (iv) Ensure appropriate furniture is installed. (v) Ensure hand rails are installed. (vi) Ensure the unit is secure, both internally and externally. (vii) Ensure hot water temperatures are safe. (viii) ensure the CPU is obtained at the completion of the building and forwarded to the DHB	Prior to occupancy

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 1.4.2.6	Consumers are provided with safe and accessible external areas that meet their needs.	PA Moderate	The courtyard is not yet landscaped or safe.	Ensure the courtyard is landscaped and safe.	Prior to occupancy
HDS(C)S.2008	Standard 1.4.3: Toilet, Shower, And Bathing Facilities	Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	PA Moderate			
HDS(C)S.2008	Criterion 1.4.3.1	There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.	PA Moderate	Fixtures, fittings and flooring have not yet been installed in any of the bathrooms	Ensure fixtures, fittings and flooring are installed in bathrooms and toilets.	Prior to occupancy
HDS(C)S.2008	Standard 1.4.6: Cleaning And Laundry Services	Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	PA Low			
HDS(C)S.2008	Criterion 1.4.6.3	Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Low	While the service only completes personal laundry, the space is small and there is no folding area for the laundry.	Ensure that there is sufficient capacity in the laundry to cater for the extra residents, that there is a designated area for folding washing and this is monitored closely by the service.	Prior to occupancy
HDS(C)S.2008	Standard 1.4.7: Essential, Emergency, And Security Systems	Consumers receive an appropriate and timely response during emergency and security situations.	PA Moderate			
HDS(C)S.2008	Criterion 1.4.7.4	Alternative energy and utility	PA Low	There is insufficient	Ensure there is sufficient	Prior to

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		sources are available in the event of the main supplies failing.		stored water to support all residents for at least three days in the event of an emergency.	stored water to support all residents for at least three days in an emergency.	occupancy
HDS(C)S.2008	Criterion 1.4.7.5	An appropriate 'call system' is available to summon assistance when required.	PA Moderate	The call bell system is not yet operational.	Ensure the call bell system is operational.	Prior to occupancy

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

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:

Wimbledon Villa currently provides dementia care for up to 27 residents. At the time of the audit there were 23 residents. This audit has assessed a new wing as suitable to provide care for 18 residents with dementia. The new wing incorporates part of the existing wing; as a result the existing wing will decrease from 27 beds to 19 beds. Performance is monitored through an internal audit programme. Wimbledon Villa has monthly staff meetings.

The service has undergone a change in management structure since the previous certification audit. There is a clinical facility manager who works from Tuesday to Saturday and has 30 years of aged care and psychiatric nursing experience. She also has experience as a manager in aged residential care. She has been a registered nurse at Wimbledon Villa since April 2012 and clinical manager since July 2013. She is supported by an administrative facility manager who has a management and business background and has been a manager at the facility since September 2010, initially as facility manager, and as administrative clinical manager since July 2013.

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

The facility is privately owned and the managers' report frequently to the owner.

(ARC D5.1). The organization has documented values, mission statement and philosophy and these are displayed in the reception area. The information is recorded in the organisation's business plan and admission agreements.

The mission statement is 'committed to providing quality residential care in a homely, safe and caring environment giving consideration to the residents' physical, mental, social and spiritual well-being and respecting their dignity'.

The current business plan includes goals and strategic direction including the plan to expand the unit with the new wing.

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): <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.

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

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: FA
Evidence: <p>During a temporary absence of the clinical facility manager, the service is managed by the registered nurse who has been at Wimbledon since April 2013 and has a strong mental health background including psychogeriatric care. When interviewed the registered nurse reports he feels confident in filling the clinical facility manager's role in a temporary absence. The registered nurse has a current APC and participates in at least eight hours training through the year. The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning. These include policies related to management of residents requiring hospital level care e.g. wound management.</p> <p>D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.</p>

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

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

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

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

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

Attainment and Risk: PA Low
Evidence: <p>There is a human resources policy that establishes the requirements for vetting of qualifications and the maintenance of practising certificates for registered nursing staff. Relevant checks are completed to validate individual qualifications and experience. A record of practising certificates is maintained for two registered nurses and other health professionals including the pharmacist, GP's and the dietitian.</p> <p>Wimbledon Villa has in place job descriptions for all positions. There are a total of 21 permanent staff. Human resources policies are in place. A comprehensive orientation programme is in place that includes the assessment of initial competencies.</p> <p>A comprehensive in-service education programme is in place. The annual training plan covers a wide range of subjects and exceeds the required eight hours annually. Discussions with staff and a review of documentation demonstrate a commitment to the education of staff that is implemented into practice. Training in the past year has included the following: restraint minimisation and the management of challenging behaviours, code of rights including advocacy, informed consent and privacy, medication management, complaint management, accident and incident reporting, pain management, sexuality and intimacy and infection control.</p> <p>D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including medication competencies. Five of five files reviewed indicate that all staff have a signed contract, orientation, training completed and evidence of recruitment. .</p> <p>The registered nurse and the clinical facility manager have a current annual practising certificate (APC).</p> <p>E4.5d The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.</p> <p>E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency. Agency staff are very rarely used and only in an emergency.</p> <p>E4.5f There are 13 caregivers, four have completed the required dementia standards and a further four have completed and are awaiting marking. Five caregivers are in the process of completing and two of these five have been at the service longer than one year. This is an area requiring improvement.</p> <p>The service intends to provide a full day orientation day for new staff prior to the opening of the new unit that will include (at a minimum) challenging behaviour management, infection control, a fire drill, medication management, food and fluid management, incident reporting, safety and security and other relevant material.</p>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: PA Low
<p>Evidence:</p> <p>A comprehensive in-service education programme is in place. The annual training plan covers a wide range of subjects and exceeds the required eight hours annually. Discussions with staff and a review of documentation demonstrate a commitment to the education of staff that is implemented into practice. Training in the past year has included the following: restraint minimisation and the management of challenging behaviours, code of rights including advocacy, informed consent and privacy, medication management, complaint management, accident and incident reporting, pain management, sexuality and intimacy and infection control.</p> <p>D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including medication competencies. Five of five files reviewed indicate that all staff have a signed contract, orientation, training completed and evidence of recruitment. .</p> <p>The registered nurse and the clinical facility manager have a current APC.</p> <p>E4.5d The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.</p> <p>E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency. Agency staff are very rarely used and only in an emergency.</p> <p>E4.5f There are 13 caregivers, four have completed the required dementia standards and a further four have completed and are awaiting marking. Five caregivers are in the process of completing.</p>
<p>Finding:</p> <p>Two of five caregivers have been at the service longer than one year and have not yet completed the required NZQA dementia standards.</p>
<p>Corrective Action:</p> <p>Ensure all staff complete the required NZQA dementia standards within the required contractual timeframes.</p>
<p>Timeframe (days): 180 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i></p>

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 staffing and skill mix policy includes a section on staffing levels rationale and is based on Ministry of Health guidelines. It is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of residents. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for the rest home residents.

The roster is planned to be graduated as residents increase.

From five to ten residents there will be (noting that at the day of opening five residents will transfer from the existing unit so this will be the minimum number of residents):

RN: 1100 hours – 1500 hours over seven days.

Caregivers: 0700 – 1430 hours, 1500 – 2315 hours, 2300 - 0715 over seven days

Diversional therapy assistant: two hours per day, Monday to Friday.

For more than 10 residents:

RN: 0800 – 1630 hours over seven days

Diversional therapy assistant: three hours Monday to Friday

Caregivers: 1X 0700 to 1515 hours.1 X 0700 to 1100 hours, 1X 1500 – 2315 hours, 1X 2300 – 0715 hours.

Additionally there will be a 'floating' night shift caregiver once there are in excess of ten residents and there is an RN on call at all times.

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:

The previous audit identified that there were not always assessments in place for all areas of resident need. Three resident files were sampled and all contain a current falls assessment, pain assessment, pressure risk assessment, nutritional assessment, continence assessment and acuity assessment. Care plans reviewed show that in all three five files all identified areas of need are included in the care plan. The previous shortfall has been addressed.
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Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

The previous audit identified that for the residents with challenging behaviour, one of three did not have documented interventions for maintaining an environment that assists the resident to be calm. This shortfall has now been addressed.

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

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

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

Attainment and Risk: PA Moderate

Evidence:

The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: Safe Management of Medicines. There is a lockable medication trolley that is used to administer medication. Staff wear an apron that states do not disturb while they are giving medication.

There are currently no controlled drugs at the service. The service uses four weekly blister packs. Medication charts have photo ID's. Eight of 13 resident medication files sighted indicate that administration of medication is documented as per policy. This is a previously identified area requiring improvement that continues to require improvement. Eight of 13 charts document a review by a GP three monthly. This is a further area requiring improvement. One resident has a medication chart that has one side which has medications that have not been signed by the GP. This is a previously identified shortfall that continues to

require improvement. One of 13 medication files sampled does not have allergies documented. Ten of 13 medications charts sampled have some PRN medications that do not document indications for use. These are further areas requiring improvement.

There is a self-administered medicines policy and procedure. Advised there were no residents self-medicating.

Medication profiles are legible and up to date.

There are no expected changes to the medication administration system when the new wing opens except that a new trolley will be purchased.

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

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

Attainment and Risk: PA Moderate
<p>Evidence:</p> <p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: Safe Management of Medicines. There is a lockable medication trolley that is used to administer medication. Staff wear an apron that states do not disturb while they are giving medication. There are currently no controlled drugs at the service. The service uses four weekly blister packs. Medication charts have photo ID's.</p>
<p>Finding:</p> <p>One of 13 medication files sampled does not have allergies documented. (ii) Ten of 13 medications charts sampled have some PRN medications that do not document indications for use. (iii) One of 13 medication charts sampled has not had all medications signed for by the prescribing doctor.(iv) Five of 13 medication charts sampled have not been reviewed by the doctor three monthly. (v) Seven of 13 medication charts sampled have regular medications that have not been signed as administered.</p>
<p>Corrective Action:</p> <p>Ensure allergies are documented. (ii) Ensure PRN medication prescriptions document indications for use. (iii) Ensure all medication charts are signed. (iv) Ensure all medications are reviewed by the GP at least three monthly. (v) Ensure medications are administered as prescribed.</p>
<p>Timeframe (days): 7 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</p>

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
<p>Evidence:</p>
<p>Finding:</p>

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: PA Low

Evidence:

The service has a workable kitchen that was fully refurbished in July 2013. The kitchen and equipment is maintained in a clean manner. The service employs cooks and kitchen hands. There is a rotating four weekly seasonal menu in place. A nutritional assessment is completed on admission and resident nutritional needs are recorded in the kitchen. Storage of food is appropriate and fridge/freezer and food temperatures are monitored daily. The maintenance person also completes a check monthly. The kitchen is well able to cater for the extra residents being approved in this audit. Changes to residents' dietary needs are communicated to the kitchen. Special diets and resident likes/dislikes records are kept in the kitchen and the cook is familiar with resident needs. The kitchen manual describes how special needs are catered for. Staff communicate with the cook daily to ensure that residents have an appropriate diet. D19.2 Staff have been trained in safe food handling. Equipment is available on an as needed basis. Residents requiring extra assistance to eat and drink are assisted, this was observed during lunch. An improvement is required around developing a system to keep food hot when transporting it to the new wing and the kitchenette in the new wing where residents will be provided with tea and coffee from is not yet complete.

E3.3f: There is evidence that there are additional nutritious snacks available over 24 hours and the kitchen is open to staff at all times.

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: PA Low
Evidence: The service has a workable kitchen that was fully refurbished in July 2013. The kitchen and equipment is maintained in a clean manner. The service employs cooks and kitchen hands. There is a rotating four weekly seasonal menu in place. A nutritional assessment is completed on admission and resident nutritional needs are recorded in the kitchen. Storage of food is appropriate and fridge/freezer and food temperatures are monitored daily. The maintenance person also completes a check monthly. The kitchen is well able to cater for the extra residents being approved in this audit.
Finding: The service has not yet purchased a system to keep meals hot when they are being served in the new unit. (ii) The kitchenette in the new wing where residents will be provided with tea and coffee from is not yet complete.
Corrective Action: Purchase a suitable system to keep meals hot while they are being served to residents in the new wing. (ii) Complete the kitchenette in the new wing.
Timeframe (days): Prior to occupancy (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 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: FA

Evidence:

There are documented policies; procedures and an emergency plan to respond to significant waste or hazardous substance management. Chemicals are stored securely in a locked storage room. There is also a locked cupboard for cleaners.

Education on hazardous substances occurs at orientation. There is personal protective equipment. There is an accident/incident system for investigating, recording and reporting incidents. There was no incident or accident reports involving infectious material, body substances or hazardous substances sighted. There is an emergency manual available to staff which includes hazardous substances. There were no incidents or accidents documented for waste or hazardous substances.

The cleaner was observed to keep all chemicals beside her at all times and described the process for keeping these safe.

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

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 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used 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.)

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: PA Moderate

Evidence:

There is a current BWOFF, expiry date 9 July 2014 and a certificate of public use that is being issued monthly with the current one having been issued on 1 November 2013. A fire evacuation approval was approved to include the new wing on 18 October 2013. There is a risk management plan that includes management of security, health and safety and emergency management. There is sufficient space so that residents are able to move around the facility freely. At the time of the audit the wall had not been painted, there were no floor coverings, window coverings had not been fitted and no furniture had been installed. Handrails are yet to be fitted. There was no power in the new unit so water temperatures were unable to be measured. These are area requiring addressing prior to occupation. Residents are able to bring their own possessions including furniture to their bedroom. There is a transportation of resident's policy. The new wing consists of an open plan lounge/dining area with a smaller lounge partially divided. There are 18 single rooms in a square format around a courtyard. The rooms are suitable in size and six rooms have external doors onto the courtyard. The courtyard is 10 metres by 11 metres and has not yet been finished or landscaped. This requires addressing prior to occupation. The owner reports a dementia provider in Sydney will be providing advice on the landscaping of the courtyard. The format of the wing is such that residents can wander in a circular format throughout the building or across the courtyard. The owner reports that residents will also be able to access the existing garden at the front of the existing unit. This will be accessed by residents going through the existing unit. The unit is not yet secure, either on outside doors or from the existing unit. This also requires addressing prior to occupation.

E3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.
E3.3e: There are quiet, low stimulus areas that provide privacy when required.
E3.4.c: There is a safe and secure outside area that is easy to access (once completed).

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Moderate

Evidence:

There is a current BWOFF, expiry date 9 July 2014 and a certificate of public use that is being issued monthly with the current one having been issued on 1 November 2012. A fire evacuation approval was approved to include the new wing on 18 October 2013. There is a risk management plan that includes management of security, health and safety and emergency management. There is sufficient space so that residents are able to move around the facility freely.

Finding:
Wall surfaces are not yet finished. (ii) Window coverings have not yet been fitted. (iii) Floor coverings have not yet been fitted. (iv) Furniture is not yet available. (v) Hand rails have not yet been installed. (vi) The unit is not yet secure. (vii) Hot water temperatures cannot yet be monitored; (viii) The building has not yet been completed and therefore the CPU is not fully signed off.
Corrective Action:
Ensure wall surfaces are painted. (ii) Ensure window coverings are installed. (iii) Ensure floor coverings are fitted (iv) Ensure appropriate furniture is installed. (v) Ensure hand rails are installed. (vi) Ensure the unit is secure, both internally and externally. (vii) Ensure hot water temperatures are safe. (viii) ensure the CPU is obtained at the completion of the building and forwarded to the DHB
Timeframe (days): Prior to occupancy (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence:
The courtyard is 10 metres by 11 metres. The owner reports a dementia provider in Sydney will be providing advice on the landscaping of the courtyard. The format of the wing is such that residents can wander in a circular format throughout the building or across the courtyard. The owner reports that residents will also be able to access the existing garden at the front of the existing unit. This will be accessed by residents going through the existing unit.
Finding:
The courtyard is not yet landscaped or safe.

Corrective Action:

Ensure the courtyard is landscaped and safe.

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

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

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

ARC E3.3d ARHSS D15.3c

Attainment and Risk: PA Moderate

Evidence:

The unit has eight rooms with ensuite bathrooms and two shared bathrooms able to cater for residents with moderate to high needs. There is a staff toilet and visitor's toilet in the existing unit.

Fixtures fittings and flooring have not yet been installed in any of the bathrooms and this requires addressing prior to occupancy.

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

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

Attainment and Risk: PA Moderate

Evidence:

The unit has eight rooms with ensuite bathrooms and two shared bathrooms able to cater for residents with moderate to high needs. There is a staff toilet and visitor's toilet in the existing unit.

Finding:

Fixtures, fittings and flooring have not yet been installed in any of the bathrooms

Corrective Action:

Ensure fixtures, fittings and flooring are installed in bathrooms and toilets.

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

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA

Evidence:

The unit consists of 18 single rooms which are roomy and airy. Furniture and fittings and wall and floor coverings have not yet been fitted or installed (See CAR 1.4.2). The clinical facility manager reports that residents will be encouraged to provide their own familiar furnishings or ornaments and pictures as they wish and as they do in the existing unit.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

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 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

The service has a large open plan lounge/dining area and a partially partitioned off extra lounge. Wall finishing's and floor fittings and furniture have not yet been completed (see CAR 1.2.4). Activities are able to occur throughout the facility. Activities also occur in the courtyard.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

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

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: PA Low
Evidence: <p>Cleaning and laundry services are well monitored throughout the internal auditing system - last audit in October 2013. All linen is laundered off site and only personal washing is completed in the small domestic size laundry that has one commercial washing machine and one commercial drier. There is insufficient capacity to manage the personal laundry for the extra residents in the Rose wing and there is no folding area for the laundry. This requires addressing prior to occupancy. Following the audit the owner has advised that the service intends to install a folding table in a storage area. Laundry (for personal items) is completed by caregivers. Following the audit the owner has informed that the service intends to employ a person to complete laundry. The laundry is situated in the existing Courtyard wing. Chemicals are stored securely. Staff receive training at orientation and through the in-service programme. There are appropriate policies and product charts. Cleaning rooms are locked when not in use.</p> <p>The laundry and cleaning rooms are designated areas and clearly labelled. There are rooms available for storage of chemicals. All chemicals are labelled with manufacturer's labels. MSDS are available in folders in the laundry and on walls.</p> <p>Staff receive training at orientation and through the in-service programme.</p>

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

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 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Attainment and Risk: PA Low
Evidence: <p>Cleaning and laundry services are well monitored throughout the internal auditing system - last audit in October 2013. All linen is laundered off site and only personal washing is completed in the small domestic size laundry that has one commercial washing machine and one commercial drier. Following the audit the owner has advised that the service intends to install a folding table in a storage area. Laundry (for personal items) is completed by caregivers. Following the audit the owner has informed that the service intends to employ a person to complete laundry. The laundry is situated in the existing Courtyard wing. Chemicals are stored securely. Staff receive training at orientation and through the in-service programme. There are appropriate policies and product charts. Cleaning rooms are locked when not in use.</p>
Finding: <p>While the service only completes personal laundry, the space is small and there is no folding area for the laundry.</p>
Corrective Action: <p>Ensure that there is sufficient capacity in the laundry to cater for the extra residents, that there is a designated area for folding washing and this is monitored closely by the service.</p>
Timeframe (days): Prior to occupancy (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: PA Moderate

Evidence:

The NZ Fire Service approved the evacuation scheme to include the new Rose wing on 18 October 2013.
D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included.
Six monthly fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment.
Fire training and security situations are part of orientation of new staff.
Emergency equipment is available at the facility. Civil emergency boxes sighted. First aid training has been provided for staff.
There is emergency lighting at the facility. There is a large cupboard with civil defence material available. The manager stated that they have spare blankets and BBQs on site. An extra water tank is planned to be installed as currently there is insufficient stored water to support all residents for at least three days in the event of an emergency. This is an area requiring improvement. There are backup emergency generators and fuel on site.
Corridors are wide enough to allow residents to pass and to get to egress points quickly in the event of a disaster.
A call bell system is being installed. Staff can contact each other between wings for assistance using pagers and a walkie talkie system. The call bell system needs to be operational prior to occupancy. There are also sensor pads beside all beds that will turn on a light in the room (or the ensuite for rooms that have an ensuite) when a resident gets out of bed at night. The staff will also be alerted via the call bell system that a resident is out of bed.

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

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 1.4.7.3 (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: PA Low
Evidence: Emergency equipment is available at the facility. Civil emergency boxes sighted. First aid training has been provided for staff. There is emergency lighting at the facility. There is a large cupboard with civil defence material available. The manager stated that they have spare blankets and BBQs on site. An extra water tank is planned to be installed as currently to provide sufficient stored water to support all residents for at least three days in the event of an emergency. This is an area requiring improvement.
Finding: There is insufficient stored water to support all residents for at least three days in the event of an emergency.
Corrective Action: Ensure there is sufficient stored water to support all residents for at least three days in an emergency.
Timeframe (days): Prior to occupancy (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

Attainment and Risk: PA Moderate
Evidence: A call bell system is being installed. All staff are alerted to call bells in either wing of the facility meaning staff from the other unit can be alerted in an emergency. There

are also sensor pads beside all beds that will turn on a light in the room (or the ensuite for rooms that have an ensuite) when a resident gets out of bed at night. The staff will also be alerted via the pager that a resident is out of bed.

Finding: The call bell system is not yet operational.
Corrective Action: Ensure the call bell system is operational.
Timeframe (days): Prior to occupancy (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence: All bedrooms and communal areas have at least one external window. General living areas and resident rooms are appropriately heated and ventilated. The service is warm on the day of the audit.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control practice is appropriate for the size, complexity, and degree of risk associated with the service. There is an established and implemented infection control programme that is linked into the risk management system. There are monthly team meetings where there is discussion and reporting of infection control matters and the consequent review of the programme. Minutes are available for staff.

The responsibilities for the infection control co-ordinator are specified in the IC manual.

The clinical facility manager interviewed is well informed about practises and reporting and states that staff can contact the DHB infection control specialist or GP if required and concerns can be written in progress notes. The infection control co-ordinator (the clinical facility manager) is responsible for the collection and collation of data.

The monthly infection data is entered into the infection register. All data is collated and analysed on infections monthly. Infection statistics are included in the team meetings. The infection rate is very low. The facility had a norovirus outbreak in May 2013 with 11 residents and seven staff affected. Public Health, the DHB and HealthCERT were notified.

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

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

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

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

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

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