# Waihi Hospital (2001) Limited

## Current Status: 21 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

Waihi is a privately owned service situated in the Waikato District Health Board. The service provides geriatric hospital, rest home and maternity services with a capacity for 20 hospital, 29 rest home residents and five maternity clients. Occupancy on the day of the audit was 36 residents. There were no maternity clients on the day of the audit however, two files were reviewed retrospectively.

There are four requirements for improvement relating to medicines management, training, care plan reviews and restraint. Two of the three previous requirements for improvement are fully implemented however the requirement for improvement relating to the GP being actively involved in the assessment and consent processes for restraint and enablers remains open.

## Audit Summary as at 21 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 21 November 2013

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

### Organisational Management as at 21 November 2013

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Continuum of Service Delivery as at 21 November 2013

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 21 November 2013

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

### Restraint Minimisation and Safe Practice as at 21 November 2013

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

### Infection Prevention and Control as at 21 November 2013

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

# HealthCERT Aged Residential Care Audit Report (version 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**

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| --- | --- |
| **Legal entity name:** | Waihi Hospital 2001 Limited |
| **Certificate name:** | Waihi Hospital |

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| **Designated Auditing Agency:** | Health Audit NZ Ltd |

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance | | | |
| **Premises audited:** | Toomey Street, Waihi | | | |
| **Services audited:** | Hospital Care for Maternity, Medical and Geriatric Services and Rest home Care | | | |
| **Dates of audit:** | **Start date:** | 21 November 2013 | **End date:** | 22 November 2013 |

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| **Proposed changes to current services (if any):** |
| None |

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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 36 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 12 | **Hours off site** | 4 |
| **Other Auditors** | XXXXX | **Total hours on site** | 12 | **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** | XXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 24 | Total audit hours off site | 10 | Total audit hours | 34 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 9 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 9 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 63 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 3 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX , Director of Auckland 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:

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| --- | --- | --- |
| 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 Tuesday, 26 November 2013

## **Executive Summary of Audit**

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| **General Overview** |
| Waihi is a privately owned service situated in the Waikato District Health Board. The service renders geriatric hospital, rest home and maternity services with a capacity for 20 hospital, 29 rest home residents and five maternity clients. Occupancy on the day of the audit was 36 residents. There were no maternity clients on the day of the audit however, two files were reviewed retrospectively. There are four requirements for improvement relating to medicines management, training, care plan reviews and restraint. Two of the three previous requirements for improvement are fully implemented however the requirement for improvement relating to the GP being actively involved in the assessment and consent processes for restraint and enablers remains open. |

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| **Outcome 1.1: Consumer Rights** |
| Waihi Hospital provides appropriate and accurate information about their services and they are committed to being open and disclosing information that may contribute to the safe and appropriate care of residents. |

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| **Outcome 1.2: Organisational Management** |
| The service has an established quality and management system which identifies and monitors risks. The previous requirements for the service to develop a business plan is now fully implemented. Day to day management is managed in an effective and efficient manner and the RN who is second in charge is currently in the process of being orientated into the facility manager’s role. The managing directorship changed between the owners of the business from the husband to the wife. There is one requirement for improvement relating to the service needing a written education and training plan / programme. Human resource management processes are conducted in accordance with good employment practices. There are adequate staff numbers at all times. Resident records are well managed and the provider ensures all resident records are maintained in a secure manner. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| Residents are admitted to the Waihi hospital under the direction of care of their General Practitioner (GP). There is a registered nurse (RN) on site 24 hours per day, supported by a health care assistant (HCA) workforce. A comprehensive admission assessment is completed on admission. Long term care plans are developed over the course of 3 weeks following admission, and identify interventions that contribute to meeting the residents assessed needs and outcomes. Short term care plans are developed in response to an immediate need. Long term care plans are reviewed 6 monthly. There is a requirement for improvement with regard to evaluation of care interventions, the short term care plan is required to show the degree of achievement or response to care.  The medication record contains all required information, however there is a requirement to have short term medications given a finish date. Residents are assessed on admission to determine competency to self-administer medications. There is a requirement that all staff complete a medicine management competency programme.  Allied health professionals are involved in care planning and delivery. A range of activities are available and an activity plan is available in each file reviewed.   Maternity – There were no maternity clients on the day of the audit however, two files were reviewed restrospectively. Clients are admitted to the annex under the direction of care of the lead maternity carer. Maternity trained health care assistants (HCA) provide care to the postnatal clients. If an unexpected situation arises in the annex the HCA rings an emergency call bell that rings in the hospital and rest home. The RN responds to this bell and attends maternity immediately. The lead maternity carer visits the woman daily to review the care plan and client objectives, and consider discharge planning. The maternity annex provides a large family focused environment for clients use and entertainment. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Residents are provided with an appropriate environment to best meet their needs. The facility comprises of the rest home, hospital and the maternity annexe.  Appropriate emergency procedures are documented and implemented and the service has an approved fire evacuation plan. The service replaced all the fire doors with self-closing doors throughout the building. The service also made improvements to the maternity annexe by including a birthing pool to the service. The building warrant of fitness is current and will expire on 11 April 2014. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| Enablers are used following consideration of alternative options and discussion and consent obtained by the resident, and the resident’s next of kin. At the last certification audit a partially attained finding was obtained with relation to 2.2.5.1. Although the GP was involved in the assessment and consent process for restraint the GP was not currently part of the review of restraints and enablers, this previous requirement for improvement remains open. A checklist is used to consider the risks of restraint compared to the risk of not using a restraint. A restraint monitoring plan is used to maintain resident safety. A requirement to document GP and power of attorney consent prior to implementing the use of a restraint is required. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection control surveillance is achieved through audit of clinical records, hand washing audits and environmental cleanliness audits. Surveillance is ongoing and reported at health and safety meetings and quarterly staff meetings. |

## **Summary of Attainment**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 10 | 0 | 2 | 2 | 0 | 0 |
| **Criteria** | 0 | 29 | 0 | 2 | 2 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 36 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 68 |

## **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 Moderate |  |  |  |
| 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 Moderate | The service does not currently have a training and education plan to guide internal and compulsory training and education opportunities for staff. Medicine management competency programme for RN’s is not current and there is no evidence of medicines management training having occurred within the last year | The service to a) have a system for identifying, planning, facilitation and recording of ongoing education of staff, b) All staff members responsible for medicines management to maintain competencies, c) medicines management training to be completed annually. | 60 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | Rest home and hospital short term care plans do not show the degree of achievement or response to care and b) observation charts are not consistently completed. | Short term care plans to reflect the degree of achievement to care and b) observations to be recorded. | 90 |
| 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 | Hospital, rest home, five of ten medication files reviewed did not have a discontinued date for short course medicines b) all prescriptions to be signed. | Short course medicines to record a discontinuation date b) all prescribed medicines to be signed. | 30 |
| HDS(RMSP)S.2008 | Standard 2.1.1: Restraint minimisation | Services demonstrate that the use of restraint is actively minimised. | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 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. | PA Low | A restraint is in use that does not include documentation of discussion or consent obtained from the resident’s GP or power of attorney. | Document discussion and consent obtained from GP and power of attorney prior to implementing a restraint. | 30 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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 1.1.9: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Residents and family confirm they have access to the information they need and that service providers openly disclose information relating to the care, treatment and information they need to be safe and have their needs met. The service confirm they have access and the ability to provide access to residents and their families to interpreter services, sighted the policy for providing interpreter services which includes contact information for interpreters in Hamilton and additional services in Wellington.  ARC 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.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

#### 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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| Interviews confirm residents and their family members know how to make a complaint and they verbalise that there is seldom a need for complaints. The residents and their family members confirm their rights are respected and whenever they verbalise concerns it is immediately followed up on and dissolved.  The service has a complaints process with easy access for residents and or their family members to complaints forms. The manager keeps complaints register that records complaints with actions taken and outcomes and close out dates documented there has been one complaint for 2013. ARC requirements are met. |

##### **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.

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

## **Outcome 1.2: Organisational Management**

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

#### Standard 1.2.3: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Quality and risk management system is documented as the quality and risk management plan supported by the business plan. Policy provide guidance for quality and risk management processes. The service have staff / quality meetings every six to eight weeks, sighted the minutes for 10 October 2013. The internal audit system includes a documented audit schedule covering clinical and non-clinical components of the quality system. The internal audit system includes findings of the audit, the sample size, the outcome of the audit and identified corrective actions with the signature of the manager and the date of sign off. Sighted the incident / accident audit of 9 July 2013, nursing documentation audit of 22 May 2013 and the medication audit of 16 August 2013. The service implements corrective action plans to address areas that require improvement, reviewed internal audit system and sighted evidence that the outcomes of the internal audit programme contributes to the improvement of the service. The previous requirement for improvement is now fully implemented. Actual and potential risks are identified in the risk management and business plans. There is a hazard reporting process for hazard management. ARC 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.

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

##### **Criterion 1.2.3.6 (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.

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

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

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

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

##### **Criterion 1.2.3.8 (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.

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

##### **Criterion 1.2.3.9 (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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The health and safety policy and procedures define the responsibilities regarding essential notification reporting for the service. The notification requirements for incident and accidents are documented on incident / accident forms. Incident forms include a diagram for indicating the site of the injury, opportunity for describing the incident, actions and follow up investigations, corrective actions and the manager signing off on the event. ARC 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.

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

##### **Criterion 1.2.4.3 (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.

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

#### 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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The manager confirms they validate professional qualification at appointment of new staff. All RN’s have current annual practicing certificates (APC’s) and the service holds current access agreements for all the midwives working at the maternity annex, sighted 11 agreements. The service currently employs seven registered nurses (RN’s) and has agreements with11 midwives.  The service offers opportunity to health care assistants for completing the aged care education programme (ACE), 16 completed the programme and ten are in the process of completing the process and eight to start the course. Medicines management training has not occurred during 2013 and the RN’s who administer medicines last completed medicines management competencies in October 2012.  Staff receive orientation and induction at employment, sighted records for five of five staff members, working across the service.  Training and development opportunities are offered and include management of challenging behaviour; 13 February and 30 April 2013; communication with a resident with dementia 19 May 2013; infection prevention and control 21 January 2013; 4 July, 6 September and 11 September 2013, Dementia and Alzheimer management 10 October 2013. The first aid training is now due. There is a required improvement relating to the service not currently having a training and education plan to guide internal and compulsory training and education opportunities for staff, medicine management competency programme for RN’s is not current and there is no evidence of medicines management training having occurred within the last year.  Clinical training is provided by the RN's and external trainers from the DHB and other organisations.  Performance reviews are conducted annually, sighted in five of five staff files. ARC requirements are not fully 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **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.

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

##### **Criterion 1.2.7.4 (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.

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

##### **Criterion 1.2.7.5 (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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Training and development opportunities are offered and include management of challenging behaviour 13 February and 30 April 2013, communication with a resident with dementia 19 May 2013, infection prevention and control 21 January 2013, 4 July, 6 September and 11 September 2013, Dementia and Altzheimer management 10 October 2013. The first aid training is now due. The service do not currently have a training and eduction plan to guide internal and compulsory training and education opportunities for staff. Clinical training is provided by the RN's and external trainers from the DHB and other organisations.  Performance reviews are conducted annually, sighted in five of five staff files. |
| **Finding:** |
| The service does not currently have a training and education plan to guide internal and compulsory training and education opportunities for staff. Medicine management competency programme for RN’s is not current and there is no evidence of medicines management training having occurred within the last year |
| **Corrective Action:** |
| The service to a) have a system for identifying, planning, facilitation and recording of ongoing education of staff, b) All staff members responsible for medicines management to maintain competencies, c) medicines management training to be completed annually. |
| **Timeframe (days):** 60 *(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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The nursing supervision policy, guidelines for comfort cares, staff recruitment guidelines and rostering policy provide guidance for service provider levels and skill mixes for a safe and appropriate service delivery. The facility manager states rosters are to meet the contractual requirements defined in the Age Related Residential Care Services Agreement (ARRC).  The general practitioner (GP) is available to provide advice to the RN, or to see patients if required from 0800 -2200 hours Monday to Friday.  In the weekends the GP availability is 0800 – 1400 hours. If the RN requires GP advice outside the above hours she contacts the nurse triage provider whom the GP practice, contracts to provide out of hours services. In acute situations the ambulance service is used to transfer residents to accident and emergency department at Waikato Hospital.   There is a registered nurse on site 24 hours per day; this RN provides care and oversight of care to the hospital, rest home and maternity annex. In addition on 3 days of the week a second registered nurse is also on site, working in the rest home section of the hospital.  Hospital - Between the hours of 0700 and 1530, there is 22 hours of health care assistant hours allowed to care for the residents. Between 1500 and 2300 hours, health care assistant hours total 18 hours. The night hours of 2300 to 0700 see 1 health care assistant on duty.   Rest home – Between 0700 hours and 1500 hours, there is 14 hours of health care assistant hours provided to care for residents. Between 1500 and 2300 12 hours of health care assistant hours are used. Between 2300 and 0700 there is 8 hours of health care assistant hours available to provide resident care.  Rosters for November and December 2013 were sighted. Residents / family interviews confirm there are adequate numbers of staff at all times. The facility manager, with the assistance of the restraint coordinator/ second in charge / RN, develops the rosters. The service has an RN on the premises at all times. ARC 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.

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

## **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Hospital and rest home residents are admitted to the Waihi hospital under the direction of care of their General Practitioner (GP). Admission assessments, care planning, evaluation and review of care provision is undertaken by a Registered Nurse (RN), working in collaboration with the GP.   Long term care plans are developed over the course of 3 weeks, with consideration to ongoing resident assessment and with the input of family. Once developed these are reviewed 6 monthly. All files sighted showed the long term care plan is reviewed 6 monthly.  Hospital and rest home residents admitted to Waihi hospital have a comprehensive admission assessment completed on admission. All files reviewed confirmed the assessment had been completed within 24 hours of admission.  Short term care plans are developed in response to an immediate need, e.g. Resident has a broken area of skin. Nine of nine short term care plans document the assessment, goal and treatment.  Hospital tracer XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Rest home Tracer  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Maternity Tracer.  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Other allied health professionals whose input into the residents wellbeing was recorded includes: physiotherapist, diabetes nurse specialist, podiatrist. A record of GP assessments and visits is included in the records, along with laboratory results and radiography results. Evidence of referral for specialist services was sighted, e.g. Referral to Waikato hospital for a possible fracture. Eleven of 11 clinical files reviewed showed evidence of multidisciplinary team involvement.  An enhancement to continuity of care since the certification audit has been the installation of a computer station at the hospital. The computer is networked to the GP’s surgery to enable the GP to login to MedTech and complete resident notes at the time of consultation. This has improved the continuity of care as now practice nurses, GP’s and hospital RN’s have access to the same clinical information.   All ARC requirements met.  Maternity - Clients have their care needs assessed on admission by their lead maternity carer. Care is planned following this assessment in collaboration with the client. Clients who require acute care or whose condition is not stable, e.g. a woman in labour, the lead maternity carer provides 1 to 1 care. Following completion of the assessment of the woman to determine her stability, a care plan is developed to enable the maternity trained health care assistant to provide prescribed cares to the client. The lead maternity carer visits the woman daily (or sooner if requested by the Waihi hospital staff) to provide evaluation and review. The maternity file reviewed confirmed assessment, planning, and daily evaluation, review and exit planning had taken place.  Clients admitted to the maternity annex have their routine care and supervision provided by health care assistants. The health care assistants have maternity specific education presented to them by health professionals with specific skills in the area being presented. One lead maternity carer interviewed advised the health care assistant’s demonstrated adequate knowledge and skills to provide appropriate care to maternity clients.   One maternity file sighted documented a team approach to maternity care which includes the lead maternity carer, the registered nurse, the health care assistant and new-born hearing screening service.   If the lead maternity carer requires a second midwife to provide assistance the Waihi hospital pays the second midwife her attendance fee. There are 11 lead maternity carers with access to the Waihi maternity annex. |

##### **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.

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

##### **Criterion 1.3.3.3 (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.

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

##### **Criterion 1.3.3.4 (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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Rest home and hospital residents care plans identify interventions that contribute to meeting the residents assessed needs and outcomes. The assessment considers the residents mobility, personal cares, sensory function, memory behaviour cognition, pain, pressure area risk, falls risk, cultural values and beliefs, spiritual values, sleep patterns nutrition, skin integrity, elimination, social and recreational needs. In addition short term care plans are developed which identify interventions to meet short term objectives and outcomes. Each record sighted identified the residents assessed needs, desired outcomes, and interventions to achieve these.   All ARC requirements met.   Maternity – File sighted identified the clients need and desired outcome and the service interventions required to achieve the desired outcome was documented. |

##### **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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| An activity plan is present in each file reviewed. The plan includes goals which address the physical, intellectual, cultural and spiritual needs of the resident, in addition resident likes and dislikes were recorded. Activities available consist of bingo, church, music, singing, crossword, hairdresser and word games. Waihi hospital owns an eight-seater bus, inclusive of one wheelchair space. Outings take place each Monday. In the morning the less mobile residents are taken for a short drive to visit the country, beach or gardens. In the afternoon the more mobile residents are taken for a walk or a picnic. On the day of the audit the activities coordinator was observed playing cards and word games with the residents, whilst others watched TV and read books. Large print books are available on site for the free use of residents. Residents interviewed stated they had a variety of activities to do, were given opportunity to take part in activities and felt included when taking part in activities.   ARC requirements are met.  Maternity – The maternity annex contains a large lounge suitable for clients to mix and mingle together or to entertain friends and family. The lounge has a TV, magazines and a dining area. There is also a large room designed for clients to be taught how to bath their baby. The annex has a kitchenette with tea and coffee making facilities, and a microwave oven. |

##### **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.

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

#### 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Hospital, rest home – Long term care plans sighted are reviewed 6 monthly. Continuous evaluation of care interventions is documented in the resident’s progress notes. Short term care plans are developed to address acute short term resident focused needs and objectives, for example a urinary tract infection or a broken area of skin. Short term care plans do not contain evaluation of response to intervention. A relative interviewed stated the resident’s care is being evaluated and they feel their family member is safe and well cared for.  GP interviewed stated that the GP is contacted if the resident’s condition changes or deteriorates. If a change or deterioration occurs out of GP hours the triage nurse is contacted or the resident is transferred to Waikato hospital via ambulance as appropriate.   ARC requirements not fully met.    Maternity – Care plans contain client goals, care interventions designed to achieve the stated goals, and evaluations of progress towards the stated goals. The lead maternity carer holds a full and complete record of the clients care plan, which they partially develop during pregnancy care. This care plan is updated during labour and after birth. The Waihi maternity annex holds a copy of the clinical record that pertains to the client’s care while a client is within the annex. One of one client interviewed stated they felt the care was appropriate and evaluated to determine effectiveness.  Where there is a change in a client’s condition the HCA will call the RN based in the hospital via an alarm call button. The RN will attend the maternity annex immediately, assuming an emergency. The RN assesses the client’s condition and telephones the lead maternity carer to seek advice regards ongoing care. When required the lead maternity care will attend the client. One of one lead maternity carer interviewed confirmed the above process as working effectively. |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Seven of ten clinical records sighted contained a short term care plan. Although the progress notes partially address the success of the intervention, the degree of achievement or response to the intervention is not recorded on the short term care plan. Observation charts are not consistently completed. |
| **Finding:** |
| 1. Rest home and hospital short term care plans do not show the degree of achievement or response to care and b) observation charts are not consistently completed. |
| **Corrective Action:** |
| 1. Short term care plans to reflect the degree of achievement to care and b) observations to be recorded. |
| **Timeframe (days):** 90 *(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.

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

#### 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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Medications are clearly labelled and stored on a locked mobile medication trolley, in a room with no access to the public. Medications for residents are supplied direct from the local pharmacy in blister packs. Residents who have new medication prescribed after their medication blister pack is made, have the medication delivered from the local pharmacy with the new medication containing the patients name, drug name and administration instructions on the label, this medication is administered by the RN on duty.  Hospital and rest home residents admitted bring their own medications. The resident’s GP reviews the medication required, medicine reconciliation takes place. The RN records the medications brought from home in the medications section of the admission form. The RN admitting the resident collects and stores the medication on the medication trolley, these medications are administered to the resident by the RN.  Medications are prescribed by the residents GP; the medications chart contains all required information including allergies and date of medication review. In addition the medication chart contains a section for PRN medications, short course drugs, telephone orders, and topical applications. All medication charts reviewed had been reviewed by the GP at 3 monthly intervals.  On the day of the audit there are six RN’s whose medicine management competency expired in October 2013. Hospital and rest home residents are assessed on admission to determine competency to self-administer their medications. Prior to a resident self-administering medication a self-medication consent is signed. The consent documents the name, strength, action, dose, route and frequency of the medication, the consent is signed by the GP and the resident. The residents competence to self-medicate is continually assesses, and the self-medication consent is reviewed 6 monthly or sooner if required. On the day of the audit one resident is self-administering insulin, documentation is sighted confirming the medication is checked by a RN prior to self-administration, the dose and time of administration is recorded.  Hospital, rest home and maternity – All residents interviewed confirmed that they were aware of the nature of their medications and felt involved in making decisions about their medication. Medications are labelled to meet legislation and medicine guidelines.  All health care assistants completed medicines management competencies in order to ensure safe and appropriate medicines management however education records showed no evidence of medicine management training this year. The RN’s have not completed medicines management competencies during the last twelve months. (refer 1.2.7.5).  ARC requirements not fully met.   Maternity – One of one file sighted included a medication record of medication administered by annex staff. This record met legislative requirements. Sixteen health care assistants who are involved in medicine management have completed competencies. |

##### **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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Ten of ten medication files sighted were reviewed three monthly by the GP. Five of ten medication files sighted had a short course drug prescribed, which did not include a finish date. The antibiotic prescribed for a resident in the rest home has not been signed. |
| **Finding:** |
| 1. Hospital, rest home, five of ten medication files reviewed did not have a discontinued date for short course medicines b) all prescriptions to be signed. |
| **Corrective Action:** |
| Short course medicines to record a discontinuation date b) all prescribed medicines to be signed. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Refer 1.2.7.5) |
| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

##### **Criterion 1.3.12.6 (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.

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

#### 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Food, fluid and nutritional needs of resdients are provided in line with nutritional guidelines. The head cook is new to the service and has been in the role for 15 months. The menus are planned on a five weekly cycle. Summer and winter menu plans are available. The Ministry of Health Food and Nutrition Guidelines 2008 are available and sighted `Healthy Eating for lactating Women` reprinted 2010. The cook interviewed orders all the food and is responsible for ensuring all fridge/freezer monitoring occurs and this is verified.  Special dietary needs for example food allergies is documented by the client on the menu. Fluids are regularly provided throughout the day. Special equipment is available for those that require this such as lipped plates, spout cups and beakers All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legilsation. Staff in the kitchen have completed food hygiene courses and infection control is effectively managed. The cooks and kitchen hands wear personal protective clothing such as aprons and hats and gloves are readily available. There is a small kitchen in the maternity annexe for clients to make drinks and heat up food. ARC requirements are met. |

##### **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.

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

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

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

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

##### **Criterion 1.3.13.5 (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.

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

## **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are no significant changes to the buildings or plant however; the service replaced all the fire doors with self-closing doors with a higher protection grade throughout the building. The doors are fire separation doors (SS15/3) and smoke separation doors (SS15/5). The building warrant of fitness is current and will expire on 11 April 2014.  The service also made improvements to the maternity annexe by including a birthing pool to the service.  ARC requirements are met. |

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

All buildings, plant, and equipment comply with legislation.

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

# 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| One file reviewed on the day of the audit documented the use of an enabler. Documentation pertaining to its use includes a consent form, consideration of alternative options, and discussion with the resident and the residents’ next of kin. At the last certification audit a partially attained finding was obtained with relation to 2.2.5.1. Although the GP was involved in the assessment and consent process for restraint the GP was not currently part of the review of restraints and enablers.  One resident’s file reviewed commenced using a restraint two days prior to the audit. A restraint assessment and checklist is completed and dated, this considered the reason for implementation, the risks associated with its use, and risk of the restraint not being used. In addition a monitoring form is completed and dated. A restraint plan of care has been commenced, which includes the frequency of monitoring and the timespan for the restraint to be used. The monitoring care plan also includes interventions to prevent resident agitation, loss of independence and implications related to physical, cultural and social needs. The consent form contains the reason for the restraint, and the type of restraint, it has been signed and dated by the restraint co-ordinator, and however neither the patient’s power of attorney nor the GP has yet signed the consent. GP interviewed stated that GP’s are frequently asked to sign restraint forms because the resident is at high risk of sustaining a fall.  ARC requirements not fully met. |

##### **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| One file is reviewed where a restraint is in use. The restraint consent form has not been signed by the GP or the resident’s power of attorney, there is no clinical documentation to suggest the GP or power of attorney has been verbally notified of the introduction of the restraint (previous finding under 2.2.5.1). |
| **Finding:** |
| A restraint is in use that does not include documentation of discussion or consent obtained from the resident’s GP or power of attorney. |
| **Corrective Action:** |
| Document discussion and consent obtained from GP and power of attorney prior to implementing a restraint. |
| **Timeframe (days):** 30 *(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 3.5: 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The Waihi hospital has one infection control co-ordinator (ICC) who is a registered nurse. The ICC is supported in the role by the hospital manager, whom collates the information collected and presents it in report and graph format. Surveillance is achieved through audit of clinical records, hand washing audits and environmental cleanliness audits.  All residents interviewed, and one family member, confirmed the hospital was kept clean and tidy.  Infection control surveillance conclusions are implemented into staff, resident and visitor education regards hand washing. Education to staff with respect to dressing technique is delivered. The rest home and hospital wings of the hospital are separate to control an infection outbreak. Surveillance is ongoing, and reported at health and safety meetings and staff meetings quarterly. All staff interviewed confirmed the above process. |

##### **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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **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.

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| **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.)* |