

Okere House Limited

Current Status: 9 January 2014

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

Okere House provides secure residential dementia care in single bedrooms in two wings. The facility is operated by Okere House Limited. This unannounced surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standard and the District Health Board contract.

This audit includes a further review of the two aspects identified as requiring improvement in the October 2011 certification audit that were recurring at the last June 2013 surveillance audit. There is one relating to activities for residents still requires improvement.

This audit also reviewed the additional 20 aspects requiring improvement during the June 2013 surveillance audit and found there are 10 recurring.

The 10 recurring issues still requiring improvement relate to: management of quality improvement including analysis of quality improvement data and development and implementation of corrective actions to address shortfalls in service delivery; completion of adverse event forms; completion of education, competencies and performance monitoring of staff; the frequency with which fire evacuations are held; currency of resident's dietary profiles and weight monitoring; management of medicines; management of activities; management of resident's documentation including but not limited to completion of risk assessments and recording of observations; and analysis of infection surveillance data.

An additional eight areas requiring improvement identified during this surveillance audit relating to: notification of reportable events to statutory authorities; human resource management including retention of practising certificates for health care professionals, evidence of police and reference checking and orientation of new staff; management of several aspects of food services; recording of resident's allergies on their medication charts; and the management of the environment to prevent resident's leaving the facility without staff knowledge.

Audit Summary as at 9 January 2014

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

Indicator	Description	Definition
	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 9 January 2014

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 9 January 2014

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.
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Continuum of Service Delivery as at 9 January 2014

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.
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Safe and Appropriate Environment as at 9 January 2014

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Restraint Minimisation and Safe Practice as at 9 January 2014

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 9 January 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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HealthCERT Aged Residential Care Audit Report (version 4.0)

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:	Okere House Limited
Certificate name:	Okere House Limited
Designated Auditing Agency:	Health Audit (NZ) Limited
Types of audit:	Surveillance Audit
Premises audited:	Okere House
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 January 2014 End date: 10 January 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	25

Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	10
Other Auditors	XXXXX	Total hours on site	12	Total hours off site	6
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	5.0

Sample Totals

Total audit hours on site	24	Total audit hours off site	21	Total audit hours	45
Number of residents interviewed		Number of staff interviewed	8	Number of managers interviewed	1
Number of residents' records reviewed	4	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	25	Number of relatives interviewed	3
Number of residents' records reviewed using tracer methodology	1			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 Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health Audit (NZ) Limited	Yes
b)	Health Audit (NZ) Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health Audit (NZ) Limited 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)	Health Audit (NZ) Limited has provided all the information that is relevant to the audit	Yes
h)	Health Audit (NZ) Limited has finished editing the document.	Yes

Dated Tuesday, 4 February 2014

Executive Summary of Audit

General Overview

Okere House provides secure residential dementia care in single bedrooms in two wings. The facility is operated by Okere House Limited. This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract.

This audit includes a further review of the two aspects of service provision identified as requiring improvement in the previous certification audit in October 2011 that had not been addressed at the last surveillance audit in June 2013. Of the two areas from the certification audit still requiring improvement following the surveillance audit in June 2013, one still requires improvement. This audit also reviewed the additional 20 aspects of service delivery identified as requiring improvement during the surveillance audit completed in June 2013. Ten of the 20 additional areas identified as requiring improvement during the June 2013 surveillance audit still require improvement. An additional eight areas requiring improvement have been identified during this surveillance audit relating to: notification of reportable events to statutory authorities; human resource management including retention of practising certificates for health care professionals, evidence of police and reference checking and orientation of new staff; management of several aspects of food services; recording of resident's allergies on their medication charts; and the management of the environment to prevent resident's leaving the facility without staff knowledge.

The 10 areas identified during the surveillance audit in June 2013 that still require improvement relate to: management of quality improvement including analysis of quality improvement data and development and implementation of corrective actions to address shortfalls in service delivery; completion of adverse event forms; completion of education, competencies and performance monitoring of staff; the frequency with which fire evacuations are held; currency of resident's dietary profiles and weight monitoring; management of medicines; management of activities; management of resident's documentation including but not limited to completion of risk assessments and recording of observations; and analysis of infection surveillance data.

Outcome 1.1: Consumer Rights

Open Disclosure procedures are in place and family members interviewed during this audit advise they are informed following adverse events or changes in their relatives condition. The issue identified during the last audit relating to the absence of documented evidence of communication with family members has been addressed as review of four resident's files indicates family contact is recorded in communication with family sheets. Improvements are still required with completion of adverse event forms as staff are not consistently completing all sections of these forms including the section to indicate that contact has been made with family following an adverse event.

Visual inspection provides evidence the Code of Health and Disability Services Consumers' Rights (the Code) information is readily displayed along with complaint forms.

The nurse manager, who is a registered nurse, is responsible for management of complaints. The area identified as requiring improvement during the last surveillance audit has been addressed. A complaints register and a 'complaints index July 2012 – December 2013' is reviewed.

The complaint that was being investigated by the Health and Disability Commissioner (HDC) during the last surveillance audit has been completed and the HDC states "the overall care provided ... is consistent with expected standards.". The HDC also asked the service provider to confirm that appropriate actions had been taken to address recommendations made by the HDC. These actions were reviewed during this audit and not all of the actions have been

completed.

The nurse manager advises there is also an ongoing complaint that is being investigated by the District Health Board. The nurse manager advises there have been no complaints investigated by the Ministry of Health, Police and Coroner since the last audit at this facility.

Outcome 1.2: Organisational Management

Okere House Limited is the governing body. The director visits the facility monthly for one and a half days during which time they review the service and set tasks for the manager to complete. The facility manager is a registered nurse who started at Okere House in July 2011 as a part time registered nurse before being appointed as the facility manager on 25 October 2011. The area identified as requiring improvement during the last audit relating to notifying the Ministry of Health of the appointment of the nurse manager has been addressed.

A quality and risk management plan and business plan reviewed. There has been some improvement noted since the last audit relating to maintenance and management of the quality and risk management systems. However, improvements are still required to some aspects of quality and risk management including analysis of quality improvement data and completion of corrective action plans to address shortfalls in service delivery.

The issues identified during the last audit relating to adverse event reporting remains. Improvements are required as reportable events are not being reported to the Ministry of Health; accident / incident forms are not being completed for all adverse events; and staff are not consistently completing all sections of the accident / incident forms.

The nurse manager is responsible for oversight of the in-service education programme. There has been some improvement with the frequency with which inservice education is provided but improvements are still required to this aspect of service delivery. Improvements are also required to other aspects of human resource management including completion of orientation by staff; completion of reference checking and criminal vetting; and retention of copies of current practising certificates for all staff who require them to practice.

There is a documented rationale for determining staffing levels and skill mixes. The minimum amount of staff is provided during the night shift and consists of two caregivers, plus the nurse manager is available after hours if required. Care staff interviewed report there is adequate staff available and that they are able to get through their work.

Outcome 1.3: Continuum of Service Delivery

The registered nurse develops, reviews, updates and evaluates residents care plans at least six monthly. Family interviewed are satisfied with the standard of care provided by staff.

Areas identified requiring improvement at last surveillance audit are partially met. There are new areas identified as requiring improvement and they relate to adhering to timeframes, documentation and care plan interventions.

There is an activities programme for the residents residing in Okere House that supports their interests, needs and strengths. Two activity officers provide group and one to one activities for residents. Family interviewed confirm satisfaction with the activities programme.

The required improvements from last surveillance audit have been partially met and there is a new area required for improvement around resident's 24 hour plans.

The nurse manager, registered nurse and senior care givers are responsible for medicine management. The medicine fridge temperatures are monitored.

There are no residents self- administering medicines at the facility.

The required improvement from the last surveillance audit is met. New areas requiring improvement have been identified at this surveillance audit and relate to weekly and six monthly checks of controlled drugs, expired medicines, medicines no longer required to return to pharmacy, staff checking the medication charts when administering medicines and signing when medicines have been administered, recording of resident's allergies and three monthly medication reviews.

Okere House has a central kitchen and on site staff that provide the food service. There is positive feedback from family about the food service.

The required improvements from last surveillance audit are partially met. New areas requiring improvement have been identified at this surveillance audit and relate to residents' dietary profiles, menu review and adherence to the menu, food safety training, food temperatures, dating of decanted foods, signing off on cleaning schedules, kitchen shelving and appropriate storage of food.

Outcome 1.4: Safe and Appropriate Environment

Okere House has a current Building Warrant of Fitness that expires on 22 June 2014. The issue identified during the last audit relating to the strong smell of faeces near the front door has been addressed as a roof mounted exhaust fan has been installed in the bathroom near the front door. The nurse manager advises this has improved the situation and no odours were detected during this audit.

Review of documentation provides evidence of a letter from New Zealand Fire Service dated 12 January 2001 advising the fire evacuation scheme for the facility has been approved. Documentation reviewed indicates the last trial evacuation was held on 26 March 2013. The nurse manager advises a trial evacuation was held in September 2013 but is not able to provide documentation to support this statement. This issue was identified as requiring improvement during the last audit and still remains an area requiring improvement.

Outcome 2: Restraint Minimisation and Safe Practice

There is a policy in place for the use of enablers. There are no residents using enablers residing in Okere House.

Outcome 3: Infection Prevention and Control

There is evidence of monthly infection control (IC) resident assessment forms / data for July, August, September, October and November 2013 and January 2014. There was no recorded IC data for December 2013 recorded. Infection control data summary for September 2013 was sighted, however there are no further evaluation and analysis of infection control data recorded and this requires an improvement.

Clinical staff interviewed (five care givers and one registered nurse) report resident's infections are reported to them verbally at handovers and written on the facility handover sheets. The Infection Control Co-ordinator /RN reports there have been no outbreaks at the facility since the last surveillance audit.

Required improvements from last surveillance audits remain partially attained.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	6	0	1	7	3	0
Criteria	0	27	0	1	12	6	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	33
Criteria	0	0	0	0	0	0	0	55

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate			
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	There is no documented evidence available indicating that quality improvement data is being analysed and evaluated to identify trends. Staff advise they are not provided with information on audit outcomes and any analysis of data.	Provide documented evidence that: (i) quality improvement data is being analysed and evaluated to identify trends and the results of this analysis is being reported to staff; and (ii) results of internal audits are being reported to staff	90
HDS(C)S.2008	Criterion 1.2.3.8	A corrective action plan addressing areas	PA Moderate	(i)Internal audits, meeting minutes and	Provide documented evidence that	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		<p>requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>		<p>accident/incident forms reviewed during this audit where areas requiring improvement have been identified but documented corrective action plans have not been developed to address the required improvements. (ii)Where corrective action plans have been developed there is no documented evidence that these corrective action plans have been implemented, monitored, and signed off as having been completed.</p>	<p>corrective action plans addressing areas identified as requiring improvement are developed, implemented, monitored for their effectiveness, and are signed off as having been completed.</p>	
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	<p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA High			
HDS(C)S.2008	Criterion 1.2.4.2	<p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct</p>	PA High	<p>The issue identified during the last audit relating to the requirement to notify the Ministry of Health of reportable events remains as there have</p>	<p>Provide documented evidence that: (i) a process for management of reportable events, including notifications to the Ministry of</p>	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		authority is notified where required.		been at least four reportable events since the last surveillance that have not been notified to the Ministry Of Health.	Health and the District Health Board, has been developed and implemented; and (ii) all reportable events are notified to the Ministry of Health and the District Health Board as required.	
HDS(C)S.2008	Criterion 1.2.4.3	The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA High	I) Unable to evidence that all adverse events are being reported and recorded. ii) Staff are not consistently completing all sections of the accident/incident forms including completing the section indicating notification to family; and the nurse manager is not consistently signing off that they have reviewed the accident/incident forms.	Provide documented evidence that all adverse events are being documented, investigated, corrective action plans are developed and implemented and monitored to address shortfalls identified.	30
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 High			
HDS(C)S.2008	Criterion 1.2.7.2	Professional qualifications are	PA Moderate	Copies of practising certificates are not	Provide evidence that copies of practising	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		validated, including evidence of registration and scope of practice for service providers.		held on site for all health care professionals who require them to practice.	certificates are held on site for all health care professionals who require them to practice.	
HDS(C)S.2008	Criterion 1.2.7.3	The appointment of appropriate service providers to safely meet the needs of consumers.	PA Moderate	Four of five staff files reviewed do not have evidence of reference checking. The nurse manager advises that it is not their practice to undertake criminal vetting for all new employees and that this has not been completed for at least four employees. Police checks reviewed on four of five staff files reviewed.	Provide evidence that reference checking and criminal vetting is undertaken for all new employees.	60
HDS(C)S.2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Moderate	Five of five staff files reviewed and there is no evidence that orientations have been completed on any of the five files.	Provide evidence that all staff complete an orientation.	60
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	i)The nurse manager who signs off the medicine competencies for staff involved in medicine management does not have a current medication competency (it was last completed in 2011). ii)There is no documented evidence	Provide evidence that (i) all staff involved in medicine management have current medication competency assessments; (ii) the registered nurse attends challenging behaviour education; (iii) the recreation officer completes first aid training if they are	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>that the registered nurse has completed challenging behaviour education.</p> <p>iii)The recreation officer drives the van with residents in it and there is no evidence they have a current first aid certificate (link 1.4.7.1)</p> <p>iv)Two of five files have no evidence of performance appraisal having been completed – one is the nurse manager. The nurse manager advises they have an appointment booked with a consultant to complete their appraisal on 25 January 2014.</p>	<p>driving residents around in the facility van; and (iv) all staff have current performance appraisals and that this is completed on a regular basis.</p>	
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	Resident documentation is not always complete and timeframes of risk assessments, initial care plans, GP initial assessments, completion of long term care plans are not always adhered to	Provide evidence timeframes are adhered to, documentation is fully completed and family involvement in care planning.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				and one of four care plan does not evidence family input into care planning.		
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	Residents' files evidence interventions are not consistent with meeting residents' needs.	Provide evidence of the required interventions specific to resident's identified needs.	90
HDS(C)S.2008	Standard 1.3.7: Planned Activities	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.	PA Moderate			
HDS(C)S.2008	Criterion 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.	PA Moderate	24 hour plans do not evidence description of activities that meet resident's needs.	Provide evidence description of activities that meet resident's needs in relation to individual diversional, motivational and recreational therapy during a 24 hour period is recorded.	90
HDS(C)S.2008	Standard 1.3.12: Medicine	Consumers receive medicines in a safe	PA High			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Management	and timely manner that complies with current legislative requirements and safe practice guidelines.				
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 High	<p>i) Controlled drugs are not checked weekly and there are is no evidence of six monthly physical counts being conducted.</p> <p>ii) There was one controlled drug that has not been required since November 2013 and has not been returned to the pharmacy.</p> <p>iii) Expired medicine was sighted.</p> <p>iv) A discrepancy in prescribing of an antibiotic was not identified for five days and administration forms had not been signed for medicines administered.</p>	Provide evidence: i) controlled drugs are checked weekly and six monthly physical counts are conducted when controlled drugs are held on site; ii) medicines are checked for expiry dates; iii) medicines no longer required are returned to pharmacy; and iv) staff check medicines against the medication chart to ensure the correct medicine is being administered and to sign the medication chart when medications are administered.	30
HDS(C)S.2008	Criterion 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.	PA High	Residents' medication charts do not always record: i) resident's allergies or no known allergies and; ii) three monthly medication reviews.	Provide evidence residents' allergies are recorded and three monthly medication reviews are conducted and recorded on medication charts.	30

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 Moderate			
HDS(C)S.2008	Criterion 1.3.13.1	Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Moderate	Menu has not been reviewed by a dietitian since 2011 and planned menu is not being followed by kitchen staff. Two of three kitchen staff have not completed food safety training.	Provide evidence the menu has been reviewed by a dietitian and is adhered to by kitchen staff and kitchen staff conduct food safety training.	90
HDS(C)S.2008	Criterion 1.3.13.2	Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA Moderate	Not all residents' dietary profiles are current and weight monitoring is not always monitored and recorded.	Provide evidence resident's dietary profile is recorded on admission, updated on a regular basis and a copy is held in the kitchen and weight monitoring is conducted and recorded.	90
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 Moderate	i) There is no recorded evidence of food temperatures being monitored. ii) Decanted foods are not dated. ii) Kitchen cleaning schedule is not signed off by staff when cleaning is completed. iv) Food is not appropriately stored (not refrigerated) and located on a trolley for over 3 hours before	Provide evidence food temperatures are monitored, decanted foods are dated, kitchen cleaning is signed off when completed, food is stored appropriately and kitchen shelving is of a material that is easily cleaned.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				being served to residents. v) Some kitchen shelves are water damaged and not able to be easily cleaned.		
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 1.4.2.6	Consumers are provided with safe and accessible external areas that meet their needs.	PA High	There have been at least four occasions when the residents have left the facility unwitnessed by staff and without staff knowledge.	Review the physical environment with a view to ensuring that residents are not able to wander away from the facility unsupervised. Advise the outcome of this review.	30
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 1.4.7.3	Where required by legislation there is an approved evacuation plan.	PA High	The last fire evacuation was held on 26 March 2013 which is more than the six month intervals allowed for in legislation.	Provide documented evidence that a trial evacuation has been held and that an evacuation is held at least six monthly.	30
HDS(IPC)S.2008	Standard 3.5: Surveillance	Surveillance for infection is carried out in accordance with agreed objectives,	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		priorities, and methods that have been specified in the infection control programme.				
HDS(IPC)S.2008	Criterion 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.	PA Low	Infection control data is not always recorded, analysed and evaluated.	Provide documented evidence that infection surveillance data is being collected, analysed, evaluated and reported in a timely manner and the results of this surveillance are being acted on to reduce the incidence of infection.	90

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

Criterion 1.1.9.1 was identified as being partially attained during the last surveillance audit in June 2013 and is now fully attained.

Open Disclosure procedures are in place and the three family members interviewed during this audit advise they are informed following adverse events or changes in their family members condition.

Review of four resident's files indicates family contact is recorded in communication with family sheets in each resident's file.

The nurse manager (NM) during interview reports there are currently no resident's who require interpreters. They report that if interpreters are required that they would be accessed via the District Health Board (DHB).

Visual inspection provides evidence the Code of Health and Disability Services Consumers' Rights (the Code) information is readily displayed along with complaint forms.

The 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.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Criterion 1.1.13.3 was partially attained during the last audit and is now fully attained.

The service has appropriate systems in place to manage the complaints processes. A complaints registers is maintained at the facility and has five complaints documented for 2013 covering the period commencing 26 June 2013 up to and including 10 September 2013. Also reviewed a 'complaints index July 2012-December 2013'. Complaints reviewed complies with Right 10 of the Code.

The nurse manager is responsible for management of complaints. Reporting on numbers of complaints occurs via monthly staff/quality meetings. The nurse manager advises there has been no complaints investigated by the Ministry of Health, Police and Coroner since the last audit at this facility. The nurse manager advises there is an ongoing complaint that is being investigated by the District Health Board.

The complaint that was being investigated by the Health and Disability Commissioner (HDC) during the last surveillance audit in June 2013 has been completed and in a letter dated 12 August 2013 the HDC states "the overall care provided ... is consistent with expected standards..". The HDC also

advises in this letter that they have asked the service provider to confirm that appropriate actions have been taken to address recommendations made by the HDC. These actions were reviewed during this audit and not all of the actions requested relating to resident documentation have been completed.

Family members interviewed (three) demonstrate an understanding and awareness of the complaints processes.

A visual inspection of the facility evidences that the complaint process is accessible and/or displayed. Review of monthly staff/quality meetings meeting minutes provides evidence of reporting of complaints.

The 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.

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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:

Criterion 1.2.1.3 was identified as requiring improvement during the last audit as the service provider had failed to notify the Ministry of Health of the appointment of a new facility manager in October 2011. This criterion is now fully attained.

Okere House Limited is the governing body. A business plan (August 2013) with goals, mission statement, philosophy of care reviewed. Also reviewed a quality improvement and risk management plan (August 2013). The service philosophy is in an understandable form and is available to residents / their family / representative or other services involved in referring clients to the service.

Monthly reports covering occupancy, wages and other financial information are provided to the director. The director visits the facility monthly for one and a half days during which time they review the service and set tasks for the manager to complete. The facility is managed by a nurse manager (NM) who is a registered nurse who started at Okere House in July 2011 as a part time registered nurse (RN) before being appointed to the position of nurse manager on 25 October 2011.

The NM is responsible for oversight of clinical care provided at Okere House and is supported by another registered nurse who works a minimum of 32 hours a week (four days at eight hours each day). The NM advises they have not received an orientation when they were appointed to their new role of NM (see link criterion 1.2.7.4). Review of the NM's file indicates an orientation has been completed on employment as a registered nurse, but there is no evidence an orientation to the role of NM has been completed.

The NM was employed at the DHB prior to their appointment at Okere House in various positions including as a service manager of mental health services, service manager mental health and health of older people, clinical services manager/clinical manager/clinical team leader and as an RN in mental health services.

The personal files and curriculum vitae for the NM and RN are reviewed during this audit and both have current practising certificates but neither have evidence of completion of orientation (see link 1.2.7.4).

Okere House is certified to provide dementia level rest home care and has contracts with the DHB to provide dementia level rest home, carer relief (day care and respite), and long term support chronic health conditions.

ARC requirements are met.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <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 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

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

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

Attainment and Risk: PA Moderate

Evidence:

All criteria in this Standard were partially attained during the last audit in June 2013. There has been some improvement noted since the last audit relating to maintenance and management of the quality and risk management systems. However, improvements are still required to some aspects of quality and risk management (see 1.2.3.6 and 1.2.3.8).

A quality and risk management plan (August 2013) reviewed along with a quality policy with philosophy and objectives. Also reviewed a business plan with goals, mission statement, philosophy of care and scope of service delivery. Completed internal audits for the period June to December 2013 reviewed along with clinical indicators for 2013. With the exception of building compliance audits there were no internal audits completed prior to June 2013. There is no family satisfaction survey available for review.

Combined staff/quality meetings have been held since 21 August 2013 and meeting minutes reviewed. Minutes reviewed provide evidence of reporting of numbers and types of adverse events, but do not provide any evidence this data has been analysed to identify trends and improvements are required (see criterion 1.2.3.6). Improvements are also required to completion of corrective action plan. Meeting minutes, adverse events and internal audits are reviewed during this audit where shortfalls have been identified. There is no documented evidence that corrective action plans are being developed, implemented and monitored to address these identified shortfalls in service delivery (see criterion 1.2.3.8).

Staff interviewed (four care givers working all three shifts and one working morning and afternoon shifts) report that meeting minutes are available for them to review and that they are required to read and sign as having read the meeting minutes. Staff also report they are not provided with information on any trends that are identified.

A policy 'Control of quality documents and records' reviewed (08 August 2013) and describes the process for document control and updating of policies. The majority of the policies reviewed have date stamps indicating reviews in August 2013.

There is a hazard reporting system available and a hazard register. Chemical safety data sheets available identifying potential risks for each area of service.

Not all of the 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.

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: <p>Combined staff/quality meetings have been held since 21 August 2013 and meeting minutes reviewed up to and including 21 November 2013. A month by month table with numbers of events by type for each month reviewed. This table includes a month by month bar graph of events by type. Infection assessment reports reviewed attached to meeting minutes (see link criterion 3.5.7)</p>
Finding: <p>There is no documented evidence available indicating that quality improvement data is being analysed and evaluated to identify trends. Staff advise they are not provided with information on audit outcomes and any analysis of data.</p>
Corrective Action: <p>Provide documented evidence that: (i) quality improvement data is being analysed and evaluated to identify trends and the results of this analysis is being reported to staff; and (ii) results of internal audits are being reported to staff</p>

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Adverse event notifications for the incident on 21 October 2013 when three residents left the facility reviewed and there is no documented corrective action plan to address this.

Internal audit tools include space to record audit comments, areas for improvement and corrective action required. Meeting minutes also includes space to record issued raised and action taken. Sections for improvements/ corrective actions are not being consistently completed.

Finding:

(i) Internal audits, meeting minutes and accident/incident forms reviewed during this audit where areas requiring improvement have been identified but documented corrective action plans have not been developed to address the required improvements.

(ii) Where corrective action plans have been developed there is no documented evidence that these corrective action plans have been implemented, monitored, and signed off as having been completed.

Corrective Action:

Provide documented evidence that corrective action plans addressing areas identified as requiring improvement are developed, implemented, monitored for their effectiveness, and are signed off as having been completed.

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

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

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

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

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

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

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

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

Attainment and Risk: PA High
Evidence: Criterion 1.2.4.3 was partially attained during the last audit and remains partially attained. There has been some improvement with recording of adverse events although improvements are still required. Staff are not consistently completing accident/incident forms for all adverse events; all sections of the accident incident forms are not being completed consistently; and the service provider is still not notifying the Ministry of Health of reportable events as required (see criteria 1.2.4.2 and 1.2.4.3.) Three family members interviewed advise they are informed following adverse events or changes in their family members condition. Not all of the 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.

Attainment and Risk: PA High
Evidence: The nurse manager advises there has been two events involving residents leaving the facility that have not been notified to the Ministry of Health as reportable events which is a condition of their certification to provide a service. The District Health Board (DHB) are aware of one of these events and have advised the nurse manager of the requirement to notify the Ministry of Health and the DHB of these types of events Review of accident and incident forms indicates there have been four occasions where residents have left the facility (05 July 2013 x one resident; 21 October 2013 x three residents; 01 November 2013 x one resident; 11 November 2013 x the same resident who left the facility on 01 November 2013).
Finding: The issue identified during the last audit relating to the requirement to notify the Ministry of Health of reportable events remains as there have been at least four reportable events since the last surveillance that have not been notified to the Ministry Of Health.
Corrective Action: Provide documented evidence that: (i) a process for management of reportable events, including notifications to the Ministry of Health and the District Health Board, has been developed and implemented; and (ii) all reportable events are notified to the Ministry of Health and the District Health Board as required.
Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA High
Evidence: There was an adverse event on the evening of day one of this audit that resulted in a resident sustaining an injury but there is no accident/incident form completed for this event. This event is not recorded in either of the resident's files or on the handover sheet. The registered nurse (RN) states she was made aware of the incident by the night care giver. Folder with completed accident/incident forms reviewed as well as an 'Accident and Incident Summary Form' which is a register of adverse events. 'Okere House Incidents 2013' graph with month by month incidents by type covering the period May to December 2013 also reviewed. Three accident/incident forms for January 2014 (two for 06 January 2014 and one for 07 January 2014) reviewed.
Finding: i)Unable to evidence that all adverse events are being reported and recorded. ii)Staff are not consistently completing all sections of the accident/incident forms including completing the section indicating notification to family; and the

nurse manager is not consistently signing off that they have reviewed the accident/incident forms.

Corrective Action:

Provide documented evidence that all adverse events are being documented, investigated, corrective action plans are developed and implemented and monitored to address shortfalls identified.

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

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

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

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

Attainment and Risk: PA High

Evidence:

Criterion 1.2.7.5 was partially attained during the last audit and remains partially attained.

The nurse manager is responsible for oversight of the in-service education programme and during interview they advise education is provided at least monthly. This finding is confirmed during review of staff education records. Improvement are still required to some aspects of the inservice education programme (see criterion 1.2.7.5). Improvements are also required to other aspects of human resource management including completion of orientation by staff (see criterion 1.2.7.4); completion of reference checking and criminal vetting (see criterion 1.2.7.3); and retention of copies of current practising certificates for all staff who require them to practice (see criterion 1.2.7.2).

Caregivers are required to complete the dementia specific unit standards and evidence reviewed indicates 11 staff have completed the dementia specific unit standards, six are half way through completing these unit standards (due to complete 14 February 2014) and one new staff member who started one week ago is yet to enrol. An external ACE assessor is contracted to provide education including the dementia specific education. Individual staff education records reviewed.

Not all ARC requirements are met.

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

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

Attainment and Risk: PA Moderate

Evidence:

Practising certificates reviewed for the nurse manager and the registered nurse.

Finding: Copies of practising certificates are not held on site for all health care professionals who require them to practice.
Corrective Action: Provide evidence that copies of practising certificates are held on site for all health care professionals who require them to practice.
Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA Moderate
Evidence: Five staff files reviewed and evidence of criminal vetting reviewed on four of these files and a form authorising police checking is reviewed on the fifth staff file. Employment agreements and job descriptions reviewed on five of five staff files. Policies and procedures relating to human resource management reviewed.
Finding: Four of five staff files reviewed do not have evidence of reference checking. The nurse manager advises that it is not their practice to undertake criminal vetting for all new employees and that this has not been completed for at least four employees. Police checks reviewed on four of five staff files reviewed.
Corrective Action: Provide evidence that reference checking and criminal vetting is undertaken for all new employees.
Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA Moderate
Evidence: New employment checklist, staff orientation part one (all staff) and part two (RN) reviewed. The NM advises all staff complete an orientation that lasts one week during which time staff are supernumerary. The NM advises they meet with all new staff on day three to review their progress and that they undertake an 'informal' performance review at the end of week three. No documented evidence to support this is available for review during this audit. Five staff files reviewed and there is no evidence that orientations have been completed on any of the five files. One of the files is the nurse manager and one is the registered nurse. The nurse manager advises they were not orientated to their new role as nurse manager and that the registered nurse (who

was appointed in June 2012) has completed part of their orientation.

Finding:

Five of five staff files reviewed and there is no evidence that orientations have been completed on any of the five files.

Corrective Action:

Provide evidence that all staff complete an orientation.

Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: PA Moderate

Evidence:

There are five staff involved in medicine management and competencies are reviewed for four of the five staff. Individual training records reviewed for each staff member as well as certificates of education. Inservice training calendar for 2013 reviewed and includes topic, presenter and date and time. There is no education plan for 2014 available and the NM advises they have identified topics for education and are currently developing well.

Finding:

- i) The nurse manager who signs off the medicine competencies for staff involved in medicine management does not have a current medication competency (it was last completed in 2011).
- ii) There is no documented evidence that the registered nurse has completed challenging behaviour education.
- iii) The recreation officer drives the van with residents in it and there is no evidence they have a current first aid certificate (link 1.4.7.1)
- iv) Two of five files have no evidence of performance appraisal having been completed – one is the nurse manager. The nurse manager advises they have an appointment booked with a consultant to complete their appraisal on 25 January 2014.

Corrective Action:

Provide evidence that (i) all staff involved in medicine management have current medication competency assessments; (ii) the registered nurse attends challenging behaviour education; (iii) the recreation officer completes first aid training if they are driving residents around in the facility van; and (iv) all staff have current performance appraisals and that this is completed on a regular basis.

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

Attainment and Risk: FA

Evidence:

There is a documented rationale (Rostering Policy) for determining staffing levels and skill mixes. Rosters reviewed and indicate adequate staffing levels. The minimum amount of staff is provided during the night shift and consists of two caregivers, plus the nurse manager is available after hours if required. Care staff interviewed report there is adequate staff available and that they are able to get through their work. Family members interviewed advise staff levels are adequate.

ARC contract requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c; 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: PA Moderate

Evidence:

In the resident files reviewed (four of four) there is evidence that the service is coordinated to promote continuity of service delivery.
Six of six clinical staff (one RN and five care givers) interviews confirm residents and/or family members are involved in all stages of service provision.
Three of three family interviews confirm their input into care planning and evaluations of care.
Four of four residents' files reviewed demonstrate the care plans are developed by the RN and demonstrate team approach into reviews and evaluations.
Family communication sheets are maintained, sighted in all four residents' files reviewed.
The auditor evidenced verbal briefing from am to pm shift.
GP interview was conducted and confirms the GP has been providing medical services for the facility for over a year. The interview with the GP confirms that staff inform the GP of any resident medical issues and concerns in timely manner

Areas identified for improvement at the last surveillance audit remains partially attained relating to documented evidence of family input into care planning, and documentation not completed in the stated timeframes. There are new areas identified as requiring improvement relating to documentation.

Related ARC requirements are not fully met.

Tracer Methodology.

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

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate
Evidence: i) Progress notes do not evidence time of entry in all four residents' files reviewed. ii) All four residents' file evidence some clinical forms (such as dietary profiles, 24 hour plans) have no date entries and/or staff signatures or both. iii) There is evidence of use of correction fluid in resident's files (three of four files). iv) GP initial assessments do not occur within ARC contract timeframes (two of four files). v) Initial care plans do not have record of date of completion (four of four files). vi) Risk assessments are not completed (four of four files). One of four files evidences no risk assessments are completed. Three of four files evidence some risk assessments such as pain and behavioural assessments are not completed. vii) Long term care plans are not completed within three weeks of admission to the facility (three of four files). viii) Observations and weight recordings are not completed monthly (four of four files). ix) Initial care plans are incomplete (three of four files). x) One of five care plans has no documented evidence of family input into the development of the care plan.
Finding: Resident documentation is not always complete and timeframes of risk assessments, initial care plans, GP initial assessments, completion of long term care plans are not always adhered to and one of four care plan does not evidence family input into care planning.
Corrective Action: Provide evidence timeframes are adhered to, documentation is fully completed and family involvement in care planning.
Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Residents' files sampled evidence the care plans do not record appropriate interventions based on assessed needs, desired outcomes or goals of the residents (refer to criterion 1.3.6.1). GPs documentation and records are current.
Three of three family interviewed confirm their relatives current care and treatments they are receiving meet their needs. Family communication forms record family communications, sighted in all residents' files sampled.
Required improvements from last surveillance audit remains partially attained relating to interventions documented following risk assessments and recordings, and there are new areas requiring improvement around documentation of interventions documented in care plans.
Related ARC requirements are not fully met.

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

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

Attainment and Risk: PA Moderate

Evidence:

- i) Second resident file of a resident admitted in September 2013 evidences the resident has a moderate falls risk rating, this is recorded on the care plan, however there are no interventions recorded for staff to follow in respect of the moderate falls risk rating.
- ii) Third resident file of a resident admitted in December 2013 evidences the resident is identified as high falls risk, this is not recorded on the initial care plan. The only record on the initial care plan indicates the resident uses a walking stick to mobilise. The long term care plan is incomplete (should have been completed one week ago) and the mobility part of the care plan records the high falls risk rating and staff supervision requirements and use of walking stick, however no details of required interventions.
- iii) Fourth resident file reviewed records the resident has been assessed as having a high risk of pressure injury. The resident's care plan states "see Waterlow chart" and there are no intervention in respect of high risk of pressure injury. This resident's mobility care plans states the resident requires supervision with walking frame, however the auditor observed two staff mobilising the resident. Interventions in respect of high falls risk are not recorded on the care plan.
- iv) Behavioural assessments have not been conducted in three of four residents' files reviewed. Resident's behavioural assessments and specific behavioural management strategies are not recorded in the care plan of the three of four residents' files reviewed

Finding:

Residents' files evidence interventions are not consistent with meeting residents' needs.

Corrective Action:

Provide evidence of the required interventions specific to resident's identified needs.

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

There are two activities officers employed at the facility and they job share and provide activities for seven days for first week and on second week six days a week. Interview with one activities officer confirms every second week on a Sunday, there is no activities officer on site, but planned activities are recorded on the activities plan for staff to follow. The interview confirms one of the activities officers is working towards diversional therapy qualification. The activities officers work from 10 am to 4 pm Monday to Friday and 10am to 3 pm on Saturday and every second Sunday. There is no activities officer during the period that sundowning occurs at the facility. The activities weekly plan is attached to outside of window at the entrance to the facility for family to see when they enter the facility. The programme has activities planned that are appropriate for residents who have dementia. Activities reflect ordinary patterns of life and include normal community activities (van outings). The activities officer who transports residents on outings, does not hold a current first aid certificate (refer to criterion 1.2.7.5). Apart from one area, the required improvements from last surveillance audit are met. Residents were observed wandering around in both lounges and outside. All residents files reviewed have social profiles and activity care plans. There is an area requiring improvement around resident's 24 hour plans. This was an area requiring improvement at the last audit and was reported under 1.3.3. (See criterion 1.3.7.1).

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: PA Moderate

Evidence:

Residents' 24 hour plans do not record how behaviour is best managed and description of activities that meet the resident's needs. The activities officer states, the activities officers complete the 24 plan for the hours they work (10am to 4pm) and care staff complete the rest of the 24 hour plan. The 24 hour plans are not signed off by the person completing the form and are not dated.

Finding:

24 hour plans do not evidence description of activities that meet resident's needs.

Corrective Action:

Provide evidence description of activities that meet resident's needs in relation to individual diversional, motivational and recreational therapy during a 24 hour period is recorded.

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

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

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

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

Attainment and Risk: FA

Evidence:

Residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident's condition changes. Care plan evaluation are conducted by the RN with input from the family, health care assistants, activities officers and GPs. Family are notified of any changes in resident's condition, evidenced in residents' files sampled and at family interviews. Time frames in relation to care planning evaluation are documented in policies and procedures, purchaser contracts, service requirements as specified in Service Agreement, applicable standards or guidelines. Residents' files evidence referral letters to specialists and other health professional. Multidisciplinary reviews are current. Required improvement from last surveillance audit is met. Related ARC requirements are met.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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

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 High
<p>Evidence:</p> <p>The area requiring improvement from the last audit is now addressed. Medicines that require refrigeration are stored in a dedicated fridge and fridge temperatures are monitored, and are sighted.</p> <p>Not all staff responsible for medicine management have current medication competency assessments (refer to criterion 1.2.7.5). The medicines are checked by a registered nurse for accuracy when new packs or medicines are delivered to the facility (refer to criterion 1.3.12.1). Medicines are stored safely at the facility. There are no residents' requiring controlled drugs at the facility on audit days; however there was a controlled drug in the controlled drug safe that had not been required for over two months, and there is no weekly count or six monthly physical count completed. There was expired medicine in the medication fridge (Paracetamol suppositories expired in January 2012). (Refer criterion 1.3.12.1)</p> <p>Breakfast medicine round conducted by the registered nurse was observed and evidenced medicines were administered safely, however the full medicine round was not observed and upon further observation and resident chart review there was evidence of discrepancy of prescribing and dispensing of a medicine and there were medicines not signed for when administered. (Refer criterion 1.3.12.1)</p> <p>The registered nurse states there are no residents self-administering their own medicines. The medicines policy includes a statement on self-administration of medicines. Sighted no medication errors reported for last six months.</p> <p>Ten of ten medication charts reviewed evidenced GPs sign for each prescribed medicine; however allergies and three monthly medication reviews are not always recorded. (Refer criterion 1.3.12.6)</p> <p>Related ARC requirements are not fully met.</p>

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 High
<p>Evidence:</p> <p>Medicines are checked by registered nurse for accuracy when new packs or medicines are delivered to the facility. There were no residents' requiring controlled drugs at the facility on audit days; however there was a controlled drug in the controlled drug safe that had not been required for over two months. The controlled drug register does not evidence weekly counts and six monthly physical count. There was expired medicine in the medication fridge (Paracetamol suppositories that expired in January</p>

2012).

One resident's medicine chart was reviewed in respect of timeframes of antibiotic prescribing and administration of same. An antibiotic was prescribed on 6 January 2014. This resident's medication chart evidences a prescription of Augmentin 500mg to be administered three times a day. The resident's blister packs were checked and evidence Cefaclor 250 mg three times a day has been dispensed by the pharmacist. The GP copy of the script (located on file) records a prescription for Cefaclor. The nurse manager states both the resident's medication chart and the GP script are sent to pharmacy for dispensing of medicines, however this discrepancy has not been picked up by the pharmacy or the staff administering medicines. Resident's signing sheets indicate the medication (Cefaclor) was administered twice a day (not the prescribed three times a day) on 6 January 2014 through to 9 January 2014. After the 9 January 2014 date entry on the administration signing sheet, there is retrospective entry of tea time medication administration for the 7th and 8th and 9th January 2014. The day of audit 10 January 2014 the RN states the medication was administered at breakfast time, however this is not signed for on the administration signing sheet. Additional medication (prednisone) administered on 10 January 2014 is also not signed for. Phone interview with the GP was conducted and discrepancy in prescribing was discussed.

Finding:

- i) Controlled drugs are not checked weekly and there are is no evidence of six monthly physical count being conducted.
- ii) There was one controlled drug that has not been required since November 2013 and has not been returned to the pharmacy.
- iii) Expired medicine was sighted.
- iv) A discrepancy in prescribing of an antibiotic was not identified for five days and administration forms had not been signed for medicines administered.

Corrective Action:

Provide evidence: i) controlled drugs are checked weekly and six monthly physical counts are conducted when controlled drugs are held on site; ii) medicines are checked for expiry dates; iii) medicines no longer required are returned to pharmacy; and iv) staff check medicines against the medication chart to ensure the correct medicine is being administered and to sign the medication chart when medications are administered.

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.

Attainment and Risk: FA

Evidence:

(Refer to criterion 1.2.7.5)

Finding:

Corrective Action:

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

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

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

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

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

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

Attainment and Risk: PA High
Evidence: Ten medication charts were reviewed and five medication charts evidence resident's allergies. Unable to evidence three monthly medication reviews are conducted, as this is not recorded on the medication charts. Sample size was increased to all residents' medication charts in respect of allergies and the increased sample size identifies 11 of the 25 medication charts do not record allergies or no known allergies.
Finding: Residents' medication charts do not always record: i) resident's allergies or no known allergies and; ii) three monthly medication reviews.
Corrective Action: Provide evidence residents' allergies are recorded and three monthly medication reviews are conducted and recorded on medication charts.
Timeframe (days): 30 (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 Moderate
Evidence: Staff and family interviews confirm food is satisfactory and residents receive adequate fluids and snacks between meals and this was observed on audit days. Five week

menu is in place; however this was reviewed by a dietitian in August 2011 and requires an improvement.

Required improvements from last surveillance audit are partially met. Fridge temperatures are within the recommended range, however, there are areas relating to dietary profiles and weight loss that remain areas requiring improvement. New areas requiring improvements have been identified at this surveillance audit and relate to menu review, menu to be adhered to by kitchen staff, food safety training, food temperatures, dating of decanted foods, signing of cleaning schedules, kitchen shelving and appropriate storage of food.

Related ARC requirements are not fully 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.

Attainment and Risk: PA Moderate

Evidence:

Policy sighted states dietitian will be consulted annually for menu review; however the last menu review by a dietitian was conducted in August 2011. The nurse manager advises the menu has been reviewed since August 2011 but a dietitian has not been involved in this review.

Interview with the cook confirms the menu was not followed by the relief cook the day prior to this audit. There was no communication between the cooks about the menu alteration and reasons for this and the cook states the previous day's menu board alerted them to the alteration made to the menu.

The nurse manager states two of three kitchen staff require food safety training – one relief cook/kitchen hand, and one new kitchen hand. The main cook has completed food safety education

Family interviews confirm food is satisfactory.

Finding:

Menu has not been reviewed by a dietitian since 2011 and planned menu is not being followed by kitchen staff. Two of three kitchen staff have not completed food safety training.

Corrective Action:

Provide evidence the menu has been reviewed by a dietitian and is adhered to by kitchen staff and kitchen staff conduct food safety training.

Timeframe (days): 90 (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: PA Moderate

Evidence:

On day of audit there were 25 residents at the facility. The dietary profile folder located in the kitchen had 27 dietary profiles located in it. There are dietary profiles in the folder for residents no longer residing at the facility, confirmed at registered nurse interview.

Of the 27 dietary profiles reviewed there is one dietary profile that was last reviewed in 2010, three were last reviewed in 2011, two in 2012 and two residents' dietary profiles do not record date of completion. Three residents do not have dietary profiles in the kitchen folder.

The typed kitchen summary residents' diet sheet of meal sizes and comments regarding puree diets, diabetic diets and allergies does not list all residents at the facility, and this kitchen summary diet sheet does not match the residents' dietary profiles e.g. resident summary diet sheet records a resident requires puree meat only, however

the resident's dietary profile indicates the full meal is to be pureed.

One of four residents' files evidences the resident admitted in October 2013 has no evidence of a dietary profile being completed (not located in resident's file or the kitchen dietary file).

Four of four residents' files evidence weight monitoring is not being conducted monthly. Two of four residents' files evidence weight has not been recorded for December 2013. One of the four residents admitted in December 2013 has not had weight recorded since admission. One of four resident's file evidences no weight monitoring for March, June, October and December 2013.

Finding:

Not all residents' dietary profiles are current and weight monitoring is not always monitored and recorded.

Corrective Action:

Provide evidence resident's dietary profile is recorded on admission, updated on a regular basis and a copy is held in the kitchen and weight monitoring is conducted and recorded.

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

Criterion 1.3.13.5 (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 Moderate

Evidence:

Visual inspection evidences adequate food stores and clean environment. Visual observation and interview with the cook confirm food temperatures are not monitored, decanted foods are not dated and kitchen cleaning schedule is not signed off by staff when cleaning is completed. There is a policy for food temperatures, sighted. Visual inspection evidences food for afternoon tea (sandwiches, cheese on crackers, buttered scones and cheese and fruit) is stored covered on a trolley from 1pm until 4 pm (not refrigerated). Cupboard under the sink (located next to the dishwasher) has shelving that is water damaged and pose on infection control risk and not able to be easily cleaned. Fridge and freezer temperatures are being monitored and are sighted.

Finding:

- i) There is no recorded evidence of food temperatures being monitored.
- ii) Decanted foods are not dated.
- ii) Kitchen cleaning schedule is not signed off by staff when cleaning is completed.
- iv) Food is not appropriately stored (not refrigerated) and located on a trolley for over 3 hours before being served to residents.
- v) Some kitchen shelves are water damaged and not able to be easily cleaned.

Corrective Action:

Provide evidence food temperatures are monitored, decanted foods are dated, kitchen cleaning is signed off when completed, food is stored appropriately and kitchen shelving is of a material that is easily cleaned.

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Criterion 1.4.2.1 was partially attained during the last audit and is now fully attained. Improvements are required to the environment to prevent residents from leaving the facility without staff knowledge (see criterion 1.4.2.6)

Visual inspection of the bathroom near the front door indicates that a roof mounted exhaust fan has been installed to alleviate the intermittent smell of faeces. The nurse manager advises this has improved the situation but also reports that if staff do not remove soiled incontinence products in a timely manner that there is an odour. No odours were detected during this audit.

Calibration sticker observed on the sit on scales indicates the scales are next due for calibration on 08 September 2013. A calibration report dated 18 September 2013 for the scales reviewed.

Okere House has a current Building Warrant of Fitness that expires on 22 June 2014 which is held in the NM office. The NM advises they have removed it from the wall by the front door to protect it from damage by residents.

Maintenance and building compliance documents reviewed. There is an external area for residents to walk around with seating and shade.

Not all of the 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.

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

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 High
Evidence: Review of the physical environment provides evidence that there is an external area with shade and seating. There have been at least four occasions when the residents have left the facility unaccompanied – two occasions where the same resident left the facility ten days apart and the NM advises they think the resident left via a window on one of these occasions; one occasion where three residents left through a gate that may have been left unlatched; and one occasion where a resident was let out the front door by a trades person. The NM also advised there was one occasion when a resident climbed over a fence, part of which has been repaired/replaced. See also criterion 1.2.3.8 and 1.2.4.3.
Finding: There have been at least four occasions when the residents have left the facility unwitnessed by staff and without staff knowledge.
Corrective Action: Review the physical environment with a view to ensuring that residents are not able to wander away from the facility unsupervised. Advise the outcome of

this review.

Timeframe (days): 30 (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:

Criterion 1.4.7.3 was partially attained during the last audit and remains partially attained.

Review of documentation provides evidence of a letter from New Zealand Fire Service dated 12 January 2001 advising the fire evacuation scheme for the facility has been approved. Documentation reviewed indicates the last trial evacuation was held on 26 March 2013. The nurse manager advises a trial evacuation was held in September 2013 but is not able to provide documentation to support this statement. This issue was identified as requiring improvement during the last audit and still remains as an area requiring improvement.

The NM advises that all staff complete first aid training and education records indicate this was completed in August 2013. The recreation officer drives the van with residents in it and does not have a current first aid certificate (see criterion 1.2.7.5). Four of the five staff files reviewed has evidence of current first aid certificates. Staff interviewed report there is at least one certified first aider on each shift.

Documented systems are in place for essential, emergency and security services. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan' in the Service Agreement.

A visual inspection of the facility evidences: information in relation to emergency and security situations is readily available; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting; oxygen is maintained in a state of readiness for use in emergency situations.

A visual inspection of the facility evidences: emergency lighting, torches, gas and BBQ for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones. There is a call bell system in place although most residents are not able to use this.

Not all ARC requirements are met.

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: PA High
Evidence: The NM advises the last fire evacuation was held in September 2013 but there is no evidence to support this. Documented evidence reviewed indicates the last trial evacuation was held on 26 March 2013. Letter from New Zealand Fire Service dated 12 January 2001 advising the fire evacuation scheme for the facility has been approved.
Finding: The last fire evacuation was held on 26 March 2013 which is more than the six month intervals allowed for in legislation.
Corrective Action: Provide documented evidence that a trial evacuation has been held and that an evacuation is held at least six monthly.
Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

Attainment and Risk: FA
Evidence:

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: Enabler use is defined in policy and staff interviews confirm knowledge of enabler and restraint use. There is no recorded evidence the registered nurse has completed challenging behaviour education (refer to criterion 1.2.7.5). There are no residents using enablers at the facility on audit days. There was one resident requiring restraint. Staff interviews confirm use of restraint for this resident is utilised and staff are knowledgeable in the use of restraint and monitoring of same. ARC requirement is 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.

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

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

Attainment and Risk: PA Low

Evidence:

There is evidence of monthly infection control (IC) resident assessment forms / data for July, August, September, October and November 2013 and January 2014. There was no recorded IC data for December 2013 recorded. Infection control data summary for September 2013 was sighted.

Required improvements from last surveillance audits remain partially attained, there are no further evaluation and analysis of infection control data recorded (see criterion 3.5.7 and link to criterion 1.2.3.6).

Clinical staff interviewed (five care givers and one registered nurse) report resident's infections are reported to them verbally at handovers and written on the facility handover sheets. The Infection Control Co-ordinator /RN reports there have been no outbreaks at the facility since last surveillance audit.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Low
Evidence: There is evidence of monthly infection control (IC) resident assessment forms / data for July, August, September, October and November 2013 and January 2014. There was no recorded IC data for December 2013 recorded. Infection control data summary for September 2013 was sighted; however there are no further evaluation and analysis of infection control data recorded. (Link to 1.2.3.6).
Finding: Infection control data is not always recorded, analysed and evaluated.
Corrective Action: Provide documented evidence that infection surveillance data is being collected, analysed, evaluated and reported in a timely manner and the results of this surveillance are being acted on to reduce the incidence of infection.
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)