# Prasad Family Foundation Limited

## Current Status: 20 January 2014

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

Brylyn Residential Care is currently a 32-bed rest home with 22 residents on the day of the audit. A partial provisional audit has been undertaken to assess the service's readiness to provide hospital level care for up to 10 residents.

The nurse manager is new to the service and currently completing her orientation period. She has seven years’ experience in DHB settings and has experience in community settings as a wound nurse specialist. She is currently supported by the previous nurse manager who will continue to provide support for as long as required. There is an orientation and training programme already implemented and a staffing rationale and draft roster that supports hospital level care.

The audit identifies that the building is suitable for hospital level care with any of the 32 bedrooms, lounges and dining areas able to accommodate hospital level equipment. There are policies and processes appropriate for providing hospital level care.

Improvements required at the previous audit around initial care plans, wound management, aspects of medication management, call bells and storage of chemicals have been addressed. Improvements continue to be required around clinical risk assessments, care plan interventions and aspects of medication management.

Further improvements are required to freezer temperatures, hoist servicing, calibrating of equipment, records for hot water temperatures and a job description for the infection control coordinator.

# 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**

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| **Legal entity name:** | Prasad Family Foundation Limited |
| **Certificate name:** | Prasad Family Foundation Limited |

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| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| **Types of audit:** | Partial Provisional Audit | | | |
| **Premises audited:** | Brylyn Residential Care | | | |
| **Services audited:** | Hospital services -geriatric; Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 20 January 2014 | **End date:** | 20 January 2014 |

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| **Proposed changes to current services (if any):** |
| This audit has assessed the service as able to cater for up to 10 hospital level residents. |

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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 22 |

## **Audit Team**

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| **Lead Auditor** | XXXXXX | **Hours on site** | 4.5 | **Hours off site** | 2.5 |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 4.5 | Total audit hours off site | 4.5 | Total audit hours | 9 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed |  | Number of staff interviewed | 2 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 4 | Number of staff records reviewed | 4 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 8 | Total number of staff (headcount) | 22 | Number of relatives interviewed |  |
| Number of residents’ records reviewed using tracer methodology |  |  |  | Number of GPs interviewed |  |

## **Declaration**

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand 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 | Not Applicable |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Thursday, 30 January 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Brylyn Residential Care is currently a 32-bed rest home with 22 residents on the day of the audit. A partial provisional audit has been undertaken to assess the service's readiness to provide hospital level care for up to 10 residents. The nurse manager is new to the service and currently completing her orientation period. She has seven years’ experience in DHB settings and has experience in community settings as a wound nurse specialist. She is currently supported by the previous nurse manager who will continue to provide support for as long as required. There is an orientation and training programme already implemented and a staffing rationale and draft roster that supports hospital level care.  The audit identifies that the building is suitable for hospital level care with any of the 32 bedrooms, lounges and dining areas able to accommodate hospital level equipment. There are policies and processes appropriate for providing hospital level care. Improvements required at the previous audit around initial care plans, wound management, aspects of medication management, call bells and storage of chemicals have been addressed. Improvements continue to be required around clinical risk assessments, care plan interventions and aspects of medication management.  Further improvements are required to freezer temperatures, hoist servicing, calibrating of equipment, records for hot water temperatures and a job description for the infection control coordinator. |

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| **Outcome 1.1: Consumer Rights** |
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| **Outcome 1.2: Organisational Management** |
| Brylyn Residential Care has a current business plan, which documents current goals for the service including the move to provide hospital level care. The business plan and goals are formally reviewed annually and informally reviewed regularly between the nurse manager and the owners. The nurse manager is new to the service and currently completing her orientation period. She has seven years’ experience in DHB settings and has experience in community settings as a wound nurse specialist. She is currently supported by the previous nurse manager who will continue to provide support for as long as required. In the absence of the manager, the senior registered nurse fills the management role. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for rest home level care with registered nurses on site each day. A draft roster has been developed for when there are hospital level residents, includes 24-hour registered nurse cover, and increased caregiver cover. The plan is to recruit more registered nurses and caregiving staff and this plan is partially implemented.  Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes appropriate for both hospital and rest home level care. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| All residents have an initial ‘ADL’ care plan and a review of files shows these are signed and dated. The four wounds at the facility are being well managed. There continues to be improvements required around clinical risk assessments and care plan interventions. The medication management system includes the medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: Safe Management of Medicines. The medication is in a locked room and resident medication files reviewed indicate that all residents have a medication chart that includes a photo and has been reviewed three monthly by a doctor. Medication is administered from a medication trolley by competent caregivers and registered nurses. Since the previous audit, the warfarin management practices have been reviewed. However, there continues to be improvements required around warfarin management, documenting allergies and administration of medication. There is also an improvement required around using bulk supply medications for rest home level residents. There are food service policies in place and the kitchen staff have all attended food handling training and a food safety course or are booked to do so. The kitchen contains appropriate cooking and storage equipment. There is a preparation area and receiving area. Diets are modified as required. Residents are encouraged to be as independent as possible and each has a rehabilitation plan in place to encourage further development of skills and quality of life. An improvement is required around freezer temperatures. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| Chemicals are stored in a locked room and a locked cupboard. Appropriate policies are available and education on hazardous substances occurs at orientation and is included in the in-service education schedule. There is personal protective equipment. The building holds a current warrant of fitness.  All 32 rooms were assessed as part of this audit to establish if they are able to be hospital rooms and all rooms are large enough to cater for hospital level residents and their associated carers and equipment.  They all have the ability to have a hospital bed in the room and for residents to be transferred between rooms in a hospital bed. The service currently has 10 hospital high – low beds and a hoist. There is an improvement required around having the hoist serviced regularly and another around ensuring all medical equipment is calibrated. A further improvement is required around the monitoring of hot water temperatures. There are two lounges and a large dining area. All are used for activities and there is ample room for fallout chairs. There are chairs in corridors that allow residents to rest when navigating hallways and hallways that allow equipment and residents to move easily and safely.  There are outdoor areas that are easily accessible for residents with ramps and paths and an internal courtyard.  Cleaning and laundry services are monitored throughout the internal auditing system and the laundry has a clean/dirty flow with soiled linen transported from the sluice room in covered bins. Staff receive training at orientation and through the in-service programme.  Appropriate training, information, and equipment for responding to emergencies is provided. Staff have completed six monthly fire drills and these are planned to continue. There is a fire evacuation plan approved by the New Zealand Fire Service. There is a staff member delegated on the roster for each duty who has a current first aid certificate. The facility is secured during the hours of darkness. The facility is light, warm and airy. Smoking is only allowed outside away from residents' rooms and communal areas. Call bells are currently installed in all areas. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
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| **Outcome 3: Infection Prevention and Control** |
| Brylyn Residential Care has an implemented infection control programme. The infection control programme its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service and is linked into the quality system. Infection control is incorporated into the quality/staff meetings and minutes are available for staff.  The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. There is an improvement required around a job description for the infection control coordinator. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 11 | 0 | 6 | 2 | 0 | 0 |
| **Criteria** | 0 | 29 | 0 | 6 | 2 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 31 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 64 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | The orientation programme has not been updated to include hospital level care and a full registered nurse orientation. Competencies appropriate for hospital level care including manual handling and hoist competencies for all staff and syringe driver competencies for registered nurses have not yet been implemented. | Update the orientation programme to make it relevant for hospital level care and include a registered nurse orientation. Ensure all staff have relevant competencies including manual handling and hoist use and registered nurses have syringe driver competencies. Since the draft report, the service has advised that The orientation booklet has been updated and now includes a registered nurse orientation. | Prior to occupancy |
| HDS(C)S.2008 | Standard 1.2.8: Service Provider Availability | Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | There are not yet sufficient registered nurses employed to provide 24 hour registered nursing cover. Since the draft report, the service advised that they are interviewing for registered nurse positions and will have their employment contracts to sign by the end of the week | Employ staff to have 24 registered nursing cover prior to admitting any hospital level residents. | Prior to occupancy |
| HDS(C)S.2008 | Standard 1.3.4: Assessment | Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.4.2 | The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | Of four resident files sampled one had no clinical risk assessments, one resident with challenging behaviour had no falls assessment, nutrition assessment or challenging behaviour assessment and one resident had no falls assessment, nutrition assessment (the resident has had recent weight loss) or on-going pain assessment (the resident has on-going pain). | Continue the plan to complete an InterRAI assessment on every resident. | 90 |
| 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 | Two of four care plans sampled do not fully document all the support required to guide staff. One resident has diabetes and is on insulin. The plan refers to a document on the management of ‘hypos’ kept on the staff room noticeboard but does not identify what blood sugar level constitutes a hypo and does not include the management of hyperglycaemia. The other file is for a resident with a pressure area. The plan states ‘have pressure area’ but does not include any interventions to reduce the risk of further pressure areas. | Ensure care plans contain interventions for all identified areas of need and fully document the support required to guide staff. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.1 | A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | (i)One of eight medication charts sampled does not document whether the resident has any allergies; (ii) One of eight medication charts sighted has regular non-packaged medications (eye drops) that have not always been documented as administered at the required times); (iii) One resident medication file sighted is for a resident on warfarin. Since the previous audit, the procedure around INR testing and warfarin management has been revised. The GP now emails or faxes the current prescription when he receives the INR results. However, on the day of the audit, the email being administered off was 13 days out of date; (iv) There is one packet of stock enemas in the drug cupboard. These enema’s are not on the standing orders list and this is an area requiring improvement. | (i)Ensure allergy status is documented on the medication file for all residents. (ii) Ensure medications are administered as prescribed. (iii) Ensure all warfarin prescriptions are current. (iv) Ensure rest home residents do not receive medications that have not been dispensed specifically for the individual resident. | 30 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | The freezer temperature has consistently been recorded as too warm with no corrective action undertaken. Since the draft report, the service advised that the freezer has been sorted and the temperature gauge reads – 18 as of the 28-1-2014. | Ensure the freezer is at the correct temperature and that corrective actions are undertaken when readings are outside the safe range. | 90 |
| 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 Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Low | (i)The hoist has not been serviced. (ii) The scales have been calibrated but other medical equipment has not. (iii) No documentation able to be sighted to show that regular hot water monitoring has occurred. Since the draft report, the service advised that the hoist and scales have been serviced 24-1-2014, and the hot water temperatures have been recorded and are at acceptable temperature levels | (i)Ensure the hoist is serviced regularly. (ii) Ensure all medical equipment is calibrated. (iii) Ensure hot water temperatures are monitored and that this is documented. | 90 |
| HDS(IPC)S.2008 | Standard 3.1: Infection control management | There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | PA Low |  |  |  |
| HDS(IPC)S.2008 | Criterion 3.1.1 | The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management. | PA Low | There is no job description for the infection control coordinator. Since the draft report, the service advised that the Job Description for the Infection Control Co- Ordinator has been completed and is now in the infection control folder | Develop a job description for the infection control coordinator. | 90 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.2: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Brylyn Residential Care provides care for up to 32 rest home residents. At the time of the audit, there are 22 residents. This audit has assessed the service as able to cater for up to 10 hospital level residents in any of the 32 rooms. Performance is monitored through an internal audit programme. Brylyn Residential Care has monthly staff meetings.  The nurse manager is new to the service and currently completing her orientation period. She has seven years’ experience in DHB settings and has experience in community settings as a wound nurse specialist. She has a current practicing certificate. She also has a postgraduate certificate in nursing science. She is currently supported by the previous nurse manager who will continue to provide support for as long as required. The DHB and HealthCERT have been informed of the change in manager (email confirmation sighted). ARC, D17.3di (rest home): The manager has maintained at least eight hours annually of professional development activities related to managing a rest home. Brylyn Residential Care is privately owned. The nurse manager reports to the owners who in turn report to the board.  The organisation has a written quality and risk management plan 2013- 2015. The quality management system identifies the vision, mission and objectives. The objectives include the plan to cater for hospital level residents. |

##### **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.

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

##### **Criterion 1.2.1.3 (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.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| During a temporary absence of the manager, the senior registered nurse manages the service. The senior registered nurse has experience of facility management and health auditing. The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning. These include policies related to management of residents requiring hospital level care e.g. wound management.  D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a human resources policy that establishes the requirements for vetting of qualifications and the maintenance of practising certificates for registered nursing staff. Relevant checks are completed to validate individual qualifications and experience. A record of practising certificates is maintained for three registered nurses (currently the nurse manager, the outgoing nurse manager and the senior registered nurse) and other health professionals including the pharmacist, GP's and the podiatrist. Brylyn Residential Care has in place job descriptions for all positions. There is 22 permanent staff. Human resources policies are in place. A comprehensive orientation programme is in place that includes the assessment of initial competencies. The orientation programme has not been updated to include hospital level care and a full registered nurse orientation. Competencies appropriate for hospital level care including manual handling and hoist competencies for all staff and syringe driver competencies for registered nurses have not yet been implemented. These are areas requiring improvement.  An in-service education programme is in place. The annual training plan covers a wide range of subjects and exceeds the required eight hours annually. Discussions with the nurse manager and the senior registered nurse and a review of documentation demonstrates a commitment to the education of staff that is implemented into practice.  D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including medication competencies. Four of four staff files reviewed indicates that all staff have a signed contract, orientation, training completed and evidence of recruitment.  The nurse manager reports that further training will be provided around the needs of hospital level care residents as the need for training is identified. The manual handling course has been booked for February and this will include use of the hoist. The registered nurse has a syringe driver competency and will attend another course (27th February 2014) to update her skills. Any new registered nurses will undergo this course too. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A comprehensive orientation programme is in place that includes the assessment of initial competencies |
| **Finding:** |
| The orientation programme has not been updated to include hospital level care and a full registered nurse orientation. Competencies appropriate for hospital level care including manual handling and hoist competencies for all staff and syringe driver competencies for registered nurses have not yet been implemented. |
| **Corrective Action:** |
| Update the orientation programme to make it relevant for hospital level care and include a registered nurse orientation. Ensure all staff have relevant competencies including manual handling and hoist use and registered nurses have syringe driver competencies. Since the draft report, the service has advised that The orientation booklet has been updated and now includes a registered nurse orientation. |
| **Timeframe (days):** Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The staffing and skill mix policy includes a section on staffing levels rationale and is based on Ministry of Health guidelines. It is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of residents. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for the rest home residents, and a draft roster been developed for the hospital residents. The draft roster includes increased caregiver hours on both morning and afternoon shifts and 24-hour registered nurse cover. The service currently has three registered nurses employed (including the nurse manager) and one registered nurse for who recruitment and appointment processes are almost complete. There is improvement required to employ staff to have 24-registered nursing cover prior to admitting any hospital level residents. The service contracts with allied health professionals on an as required basis. The nurse manager reports there have been discussions with the currently contracted physiotherapist and dietitian and they are able to cater for the increased needs when the service has hospital level residents. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The staffing and skill mix policy includes a section on staffing levels rationale and is based on Ministry of Health guidelines. It is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of residents. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for the rest home residents, and a draft roster been developed for the hospital residents. The draft roster includes increased caregiver hours on both morning and afternoon shifts and 24-hour registered nurse cover. The service currently has three registered nurses employed (including the nurse manager) and one registered nurse for who recruitment and appointment processes are almost complete.  The service contracts with allied health professionals on an as required basis. The nurse manager reports there have been discussions with the currently contracted physiotherapist and dietitian and they are able to cater for the increased needs when the service has hospital level residents. |
| **Finding:** |
| There are not yet sufficient registered nurses employed to provide 24 hour registered nursing cover. Since the draft report, the service advised that they are interviewing for registered nurse positions and will have their employment contracts to sign by the end of the week |
| **Corrective Action:** |
| Employ staff to have 24 registered nursing cover prior to admitting any hospital level residents. |
| **Timeframe (days):** Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous audit identified that the ADL plan (the initial care plan) was not completed in some files and not always signed and dated. Of the four files sampled, all had a fully completed ADL plan and two of these were signed and dated. The two files with unsigned and undated ADL plans were admitted in 2009. The file was extended to include the three residents most recently admitted and all had a fully completed ADL plan that was signed and dated on the day of admission. The previous shortfall has been addressed. |

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

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

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

#### Standard 1.3.4: Assessment **(**HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The previous audit identified that assessments were not completed for all residents including admission assessments, challenging behaviour assessments, pain assessments, nutrition assessments and falls assessments for some residents. It is noted that the service is transitioning to using InterRAI assessments and one file sampled had a completed InterRAI assessment. The registered nurse interviewed reports four other residents have completed InterRAI assessments and there is a plan to complete InterRAI assessments on all new residents and to change all existing residents to InterRAI assessments when their care plans are due for review. The risk rating for this criterion is low to reflect the partially implemented plan to ensure all residents have an InterRAI assessment. Four files were sampled and all had an initial assessment. This is an improvement since the previous audit. One of four files had a falls assessment, two of four files had a nutrition assessment and one resident with challenging behaviour had no challenging behaviour assessment. One resident with identified pain did not have an on-going pain assessment. These areas continue to require improvement. |

##### **Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)**

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The previous audit identified that assessments were not completed for all residents including admission assessments, challenging behaviour assessments, pain assessments, nutrition assessments and falls assessments for some residents. It is noted that the service is transitioning to using InterRAI assessments and one file sampled had a completed InterRAI assessment. The registered nurse interviewed reports four other residents have completed InterRAI assessments and there is a plan to complete InterRAI assessments on all new residents and to change all existing residents to InterRAI assessments when their care plans are due for review. Four files were sampled and all had an initial assessment. This is an improvement since the previous audit. One of four files had a falls assessment, two of four files had a nutrition assessment |
| **Finding:** |
| Of four resident files sampled one had no clinical risk assessments, one resident with challenging behaviour had no falls assessment, nutrition assessment or challenging behaviour assessment and one resident had no falls assessment, nutrition assessment (the resident has had recent weight loss) or on-going pain assessment (the resident has on-going pain). |
| **Corrective Action:** |
| Continue the plan to complete an InterRAI assessment on every resident. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The previous audit identified that care plans did not fully document the support required to guide staff. Two of the four files sampled for this audit contain appropriate interventions around all areas of need. Two files sampled do not fully document all the support required to guide staff. One resident has diabetes and is on insulin. The plan refers to a document on the management of ‘hypos’ kept on the staff room noticeboard but does not identify what blood sugar level constitutes a hypo and does not include the management of hyperglycaemia. The other file is for a resident with a pressure area. The plan states ‘has pressure area’ but does not include any interventions to reduce the risk of further pressure areas. This area continues to require improvement.  The previous audit identified shortfalls in wound management. The service currently has four wounds including one pressure area and all have an assessment, a management plan and evidence of on-going and timely review. The previous shortfall had been addressed. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The previous audit identified that care plans did not fully document the support required to guide staff. Two of the four files sampled for this audit contain appropriate interventions around all areas of need.  The previous audit also identified shortfalls in wound management. The service currently has four wounds including one pressure area and all have an assessment, a management plan and evidence of on-going and timely review. The previous shortfall had been addressed. |
| **Finding:** |
| Two of four care plans sampled do not fully document all the support required to guide staff. One resident has diabetes and is on insulin. The plan refers to a document on the management of ‘hypos’ kept on the staff room noticeboard but does not identify what blood sugar level constitutes a hypo and does not include the management of hyperglycaemia. The other file is for a resident with a pressure area. The plan states ‘have pressure area’ but does not include any interventions to reduce the risk of further pressure areas. |
| **Corrective Action:** |
| Ensure care plans contain interventions for all identified areas of need and fully document the support required to guide staff. |
| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous audit identified there were no documented evaluations that indicate the progress to meeting the goals or current condition/response to support provided. In each of the four files sampled care plans are reviewed six monthly (signed and dated as reviewed) and amended as required. All document the progress toward meeting the identified goals. This shortfall has been addressed. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: Safe Management of Medicines. A lockable medication trolley is used to administer medication and kept in the treatment room when not being used.  Controlled drugs are stored in a locked safe in the locked pharmacy and are checked out by two staff when they are to be administered and the controlled drug register updated accordingly. This is an improvement since the previous audit. Controlled dug weekly stocktakes have occurred. The registered nurses and medication competent caregivers administer medications. The service uses four weekly blister packs. Medication charts have photo ID’s and this is an improvement since the previous audit. Seven of eight medication charts sampled have allergies documented. This previously identified shortfall continues to require improvement.  One of eight medication charts sighted has regular non-packaged medications (eye drops) that have not always been documented as administered at the required times). This previously identified shortfall continues to require improvement. One resident medication file sighted is for a resident on warfarin. Since the previous audit, the procedure around INR testing and warfarin management has been revised. The GP now emails or faxes the current prescription when he receives the INR results. However, on the day of the audit the email being administered off was 13 days out of date. Warfarin management continues to be an area requiring improvement.  There were no respite residents at the time of the audit so medication management for respite residents could not be verified. There is a self-administered medicines policy and procedure. Advised there were no residents self-medicating on the day of audit. Eight of eight medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.  Medication profiles are legible and up to date.  There are no expected changes to the medication administration system when hospital level residents are brought into the service, as medication will continue to be administered from the medication trolley.  There is one packet of stock enemas in the drug cupboard. These enema’s are not on the standing orders list and this is an area requiring improvement. |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: Safe Management of Medicines. A lockable medication trolley is used to administer medication and kept in the treatment room when not being used.  Controlled drugs are stored in a locked safe in the locked pharmacy and are checked out by two staff when they are to be administered and the controlled drug register undated accordingly. This is an improvement since the previous audit. Controlled dug weekly stocktakes have occurred. The registered nurses and medication competent caregivers administer medications. The service uses four weekly blister packs. Medication charts have photo ID’s and this is an improvement since the previous audit. Seven of eight medication charts sampled have allergies documented.  One resident medication file sighted is for a resident on warfarin. Since the previous audit, the procedure around INR testing and warfarin management has been revised. The GP now emails or faxes the current prescription when he receives the INR results.  There were no respite residents at the time of the audit so medication management for respite residents could not be verified. There is a self-administered medicines policy and procedure. Advised there were no residents self-medicating on the day of audit. Eight of eight medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.  Medication profiles are legible and up to date.  There are no expected changes to the medication administration system when hospital level residents are brought into the service, as medication will continue to be administered from the medication trolley. |
| **Finding:** |
| (i)One of eight medication charts sampled does not document whether the resident has any allergies; (ii) One of eight medication charts sighted has regular non-packaged medications (eye drops) that have not always been documented as administered at the required times); (iii) One resident medication file sighted is for a resident on warfarin. Since the previous audit, the procedure around INR testing and warfarin management has been revised. The GP now emails or faxes the current prescription when he receives the INR results. However, on the day of the audit, the email being administered off was 13 days out of date; (iv) There is one packet of stock enemas in the drug cupboard. These enema’s are not on the standing orders list and this is an area requiring improvement. |
| **Corrective Action:** |
| (i)Ensure allergy status is documented on the medication file for all residents. (ii) Ensure medications are administered as prescribed. (iii) Ensure all warfarin prescriptions are current. (iv) Ensure rest home residents do not receive medications that have not been dispensed specifically for the individual resident. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service has a workable kitchen. The kitchen and equipment is maintained in a clean manner. The service employs cooks and kitchen hands. All cooks except the one most recently employed have food safety certificates. The newly employed cook is booked to attend this course. This is an improvement since the previous audit. There is a rotating four weekly seasonal menu in place. A dietitian last reviewed the menu in October 2013. This is an improvement since the previous audit. A nutritional assessment is completed on admission (link 1.3.4.2) and resident nutritional needs are recorded in the kitchen. Storage of food is appropriate and fridge/freezer and food temperatures are monitored daily. The freezer temperature has consistently been recorded as too warm with no corrective action undertaken. This is an area requiring improvement. It is noted that the freezer was at an appropriate temperature on the day of the audit. Changes to residents’ dietary needs are communicated to the kitchen. Special diets and resident likes/dislikes records are kept in the kitchen and the cook is familiar with resident needs. The kitchen manual describes how special needs are catered for. Staff communicate with the cook daily to ensure that residents have an appropriate diet.  Equipment is available on an as needed basis. Residents requiring extra assistance to eat and drink are assisted, this was observed during lunch. There is already special equipment for eating e.g. lipped plates and thick handled spoons.  The service intends purchasing hot plates to keep meals warm for hospital residents on an as needed basis and has organised a supplier to facilitate this. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service has a workable kitchen. The kitchen and equipment is maintained in a clean manner. The service employs cooks and kitchen hands. All cooks except the one most recently employed have food safety certificates. The newly employed cook is booked to attend this course. This is an improvement since the previous audit. There is a rotating four weekly seasonal menu in place. A dietitian last reviewed the menu in October 2013. This is an improvement since the previous audit. A nutritional assessment is completed on admission (link 1.3.4.2) and resident nutritional needs are recorded in the kitchen. Storage of food is appropriate and fridge/freezer and food temperatures are monitored daily. It is noted that the freezer was at an appropriate temperature on the day of the audit. |
| **Finding:** |
| The freezer temperature has consistently been recorded as too warm with no corrective action undertaken. Since the draft report, the service advised that the freezer has been sorted and the temperature gauge reads – 18 as of the 28-1-2014. |
| **Corrective Action:** |
| Ensure the freezer is at the correct temperature and that corrective actions are undertaken when readings are outside the safe range. |
| **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 1.4.1: Management Of Waste And Hazardous Substances **(**HDS(C)S.2008:1.4.1)

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are documented policies; procedures and an emergency plan to respond to significant waste or hazardous substance management. Chemical safety training was provided November 2012. Chemicals are stored securely in a locked storage room and this is an improvement since the previous audit. There is also a locked cupboard for cleaners.  Education on hazardous substances occurs at orientation. There is personal protective equipment. There is an accident/incident system for investigating, recording and reporting incidents. There was no incident or accident reports involving infectious material, body substances or hazardous substances sighted. There is an emergency manual available to staff which includes hazardous substances. There were no incidents or accidents documented for waste or hazardous substances.  The cleaner was observed to keep all chemicals beside her at all times. |

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

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

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

##### **Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)**

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a current BWOF, expiry date 20 September 2014 and a fire evacuation approval approved January 2014. There is a risk management plan that includes management of security, health and safety and emergency management. There is sufficient space so that residents are able to move around the facility freely. There is non-slip lino in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted.  Residents are able to bring their own possessions including furniture to their bedroom. There is a transportation of resident’s policy.  The 32 rooms are suitable for hospital care are large; all have one and a half opening doors or an extra-large door. All rooms can accommodate equipment e.g. hoists, extra staff if required and all can be accessed by a hospital bed and ambulance stretcher.  There are outdoor areas that are accessible by residents using mobility aids.  The service currently has 10 high low hospital beds and one hoist. They also have sufficient shower chairs. Further hoists and equipment including fall out chairs will be purchased on an as needs basis. The hoist has not been serviced and this is an area requiring improvement. The scales have been calibrated but other medical equipment has not and this is also an area requiring improvement. Hot water temperatures are planned to be checked weekly. However, there was no documentation able to be sighted to show that regular hot water monitoring has occurred and this is a further area requiring improvement. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a current BWOF, expiry date 20 September 2014 and a fire evacuation approval approved January 2014. There is a risk management plan that includes management of security, health and safety and emergency management. There is sufficient space so that residents are able to move around the facility freely. There is non-slip lino in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted.  Residents are able to bring their own possessions including furniture to their bedroom. There is a transportation of resident’s policy.  The 32 rooms are suitable for hospital care are large; all have one and a half opening doors or an extra-large door. All rooms can accommodate equipment e.g. hoists, extra staff if required and all can be accessed by a hospital bed and ambulance stretcher. Eight of the rooms (all within the main facility) are very large studio units. The service currently has 10 high low hospital beds and one hoist. Further hoists and equipment will be purchased on an as needs basis. |
| **Finding:** |
| (i)The hoist has not been serviced. (ii) The scales have been calibrated but other medical equipment has not. (iii) No documentation able to be sighted to show that regular hot water monitoring has occurred. Since the draft report, the service advised that the hoist and scales have been serviced 24-1-2014, and the hot water temperatures have been recorded and are at acceptable temperature levels |
| **Corrective Action:** |
| (i)Ensure the hoist is serviced regularly. (ii) Ensure all medical equipment is calibrated. (iii) Ensure hot water temperatures are monitored and that this is documented. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The eight studio units all have a large bathroom that is sufficient in size to cater for the needs of hospital level residents. There is one further room with an ensuite although this is not large enough to cater for a resident needing a hoist or more than one caregiver. However the three large communal disabled size bathrooms are well able to cater for all residents, all residents can access shower, and toilet facilities close by that can accommodate hoists and extra staff.  There is a staff toilet and visitor’s toilet. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All 32 residents’ rooms in the designated hospital rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in bathrooms in the eight studio units. Doorways into residents' rooms and communal areas are wide enough for wheelchairs, hospital beds and other mobility aids. |

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

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

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

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

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

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has a large lounge and a large dining room that already accommodates 32 residents with ease. A second smaller dining room can be used to preserve the dignity of residents with higher needs.  The dining room and lounges can accommodate hospital lazy boys and fall out chairs if required.  Activities occur throughout the facility including activities in the lounges and main dining room. Activities also occur in the courtyard and in outdoor areas.  Residents are able to access areas for privacy if required and there a number of alcoves, where people can sit when walking through hallways. |

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Cleaning and laundry services are well monitored throughout the internal auditing system - last audit in October 2013. Laundry has a clean/dirty flow and chemicals are stored securely. Staff receive training at orientation and through the in-service programme. There are appropriate policies and product charts. Cleaning rooms are locked when not in use.  The laundry and cleaning rooms are designated areas and clearly labelled. There are rooms available for storage of chemicals. All chemicals are labelled with manufacturer’s labels. MSDS are available in folders in the laundry and on walls. All chemicals were noted to be secure during the audit and this is an improvement since the previous audit. The cleaner was observed during the audit to have the trolley with her at all times. Staff receive training at orientation and through the in-service programme.  There is a sluice room. |

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

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

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

##### **Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)**

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

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

#### Standard 1.4.7: 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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The NZ Fire Service approved the evacuation scheme on 14 January 2014. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff.  Emergency equipment is available at the facility. Civil emergency boxes were sighted. First aid training has been provided for staff and the roster designates a person on each duty with a current first aid certificate. There is emergency lighting at the facility. There is a large cupboard with civil defence material available. There is sufficient stored water to support residents for at least three days in the event of an emergency. Corridors are wide enough to allow residents to pass and to get to egress points quickly in the event of a disaster.  All rooms and communal areas have call bells. This is an improvement since the previous audit. |

##### **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.

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

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

Where required by legislation there is an approved evacuation plan.

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

##### **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.

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

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

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

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

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

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

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

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

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

ARC D15.2f ARHSS D15.2g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| All bedrooms and communal areas have at least one external window. There are designated outside areas for residents to smoke.  General living areas and resident rooms are appropriately heated and ventilated. There are a combination of radiators and heat pumps. The service is a pleasant temperature on the day of the audit. |

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

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

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

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

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

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

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

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

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

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The infection control practice is appropriate for the size, complexity, and degree of risk associated with the service. An established and implemented infection control programme is linked into the risk management system. There are staff meetings where there is discussion and reporting of infection control matters and the consequent review of the programme. Minutes are available for staff. The nurse manager interviewed (the infection control coordinator) is well informed about practises and reporting and states that staff can contact the registered nurse, GP or nurse manager if required and concerns can be written in progress notes. The infection control co-ordinator reports she is responsible for the collection and collation of data. An improvement is required to document a job description for the infection control coordinator. The monthly infection data is entered into the infection register. All data is collated and analysed on infections monthly. Infection statistics are included in the staff/quality meetings. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The infection control practice is appropriate for the size, complexity, and degree of risk associated with the service. An established and implemented infection control programme is linked into the risk management system. There are staff meetings where there is discussion and reporting of infection control matters and the consequent review of the programme. Minutes are available for staff. The nurse manager interviewed (the infection control coordinator) is well informed about practises and reporting and states that staff can contact the registered nurse, GP or nurse manager if required and concerns can be written in progress notes. The infection control co-ordinator reports she is responsible for the collection and collation of data. |
| **Finding:** |
| There is no job description for the infection control coordinator. Since the draft report, the service advised that the Job Description for the Infection Control Co- Ordinator has been completed and is now in the infection control folder |
| **Corrective Action:** |
| Develop a job description for the infection control coordinator. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |