# McKenzie Healthcare Limited

## Current Status: 6 December 2013

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

McKenzie Healthcare provides care for up to 55 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 48 residents; 17 residents at rest home level and 31 residents at hospital level. A chief executive officer manages the service. A full time clinical services manager who has been with the service for 28 years manages clinical services. Family and residents interviewed all spoke very positively about the care and support provided.

Three of the four shortfalls identified at the previous audit have been addressed by the service. These were around care planning documentation and infection surveillance. One short fall around short term care planning continues to require improvement.

This audit identified further improvements required by the service around medication documentation and care planning interventions.

## Audit Summary as at 6 December 2013

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

### Consumer Rights as at 6 December 2013

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

### Organisational Management as at 6 December 2013

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

### Continuum of Service Delivery as at 6 December 2013

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

### Safe and Appropriate Environment as at 6 December 2013

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

### Restraint Minimisation and Safe Practice as at 6 December 2013

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

### Infection Prevention and Control as at 6 December 2013

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

**HealthCERT Aged Residential Care Audit Report (version 3.91)**

## **Introduction**

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

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

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

## **Audit Report**

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| --- | --- |
| **Legal entity name:** | McKenzie HealthCare Limited |
| **Certificate name:** | McKenzie HealthCare Limited |

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

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| **Types of audit:** | Surveillance | | | |
| **Premises audited:** | McKenzie Healthcare | | | |
| **Services audited:** | Hospital and Rest Home | | | |
| **Dates of audit:** | **Start date:** | 6 December 2013 | **End date:** | 6 December 2013 |

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| **Proposed changes to current services (if any):** |
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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 48 |

## **Audit Team**

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| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 6 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 1.5 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 11.5 | Total audit hours | 27.5 |

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| Number of residents interviewed | 7 | Number of staff interviewed | 7 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 3 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 70 | Number of relatives interviewed | 10 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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| --- | --- | --- |
| a) | I am a delegated authority of the DAA | Yes |
| b) | the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | the DAA has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | the DAA has provided all the information that is relevant to the audit | Yes |
| h) | the DAA has finished editing the document. | Yes |

Dated Friday, 31 January 2014

## **Executive Summary of Audit**

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| **General Overview** |
| McKenzie Healthcare provides care for up to 55 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 48 residents (17 residents at rest home level and 31 residents at hospital level including one resident receiving palliative care). A chief executive officer manages the service. A full time clinical services manager who has been with the service for 28 years manages clinical services. Family and residents interviewed all spoke very positively about the care and support provided.  Three of the four shortfalls identified at the previous audit have been addressed by the service. These were around care planning documentation and infection surveillance. One short fall around short term care planning continues to require improvement. This audit identified further improvements required by the service around medication documentation and care planning interventions. |

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| **Outcome 1.1: Consumer Rights** |
| Residents and relatives spoke positively about care provided at McKenzie Healthcare. Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident, care/medical issues or complaints arise. Complaints processes are implemented and complaints and concerns are managed and documented. |

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| **Outcome 1.2: Organisational Management** |
| The service has a business plan and quality and risk management plan 2013. Key components of the quality management system link to a number of meetings including quality meetings. A 2012 resident satisfaction survey has been completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings. Quality actions have resulted in a number of quality improvements for both residents and staff. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. 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 and covers relevant aspects of care and support. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. |

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| **Outcome 1.3: Continuum of Service Delivery** |
| McKenzie Healthcare has implemented systems that evidence each stage of service provision is developed with resident and/or family input, according to timeframes and is coordinated to promote continuity of service delivery. Residents and family interviewed confirm their input into care planning and care plan evaluations. Improvements are required whereby all interventions are provided in response to residents assessed needs. Evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. Where progress is different from expected, the service responds by initiating changes to the care plan. Further improvements around short term care plans are required. This remains a shortfall from previous audit. The previous audit identified that there had been shortfalls around development of care plans by the enrolled nurse and care plans reflecting the results from assessments. These areas have been addressed and monitored by the service. Planned activities are appropriate to the group setting. Residents and family interviewed confirm satisfaction with the activities programme. Residents' files evidence individual activities are provided either within group settings or on a one-on-one basis. There is an appropriate medicine management system in place. An improvement is required around transcribing of medication orders. Medication competencies are completed for staff with medication administration responsibilities. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. A five week menu is implemented and residents' individual needs are identified, documented and reviewed on regular basis. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The service displays a current building warrant of fitness. |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There is a restraint policy that includes definitions of restraint and enablers. There are 10 residents assessed as requiring enablers and no residents with restraint. Staff are trained in restraint minimisation, de-escalation and challenging behaviour. |

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| **Outcome 3: Infection Prevention and Control** |
| Infection control data is collated monthly and reported to quality, health and safety and infection control meeting. The meetings include the monthly infection control report. All infections are documented on the infection monthly register. The documentation of all infections has been addressed and monitored by the service. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme and reviewed annually. Evaluation of effectiveness of infection control training is occurring. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 13 | 0 | 0 | 3 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 0 | 3 | 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 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| 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 | One resident had sustained a head laceration following a fall – neurological observations were not conducted; one resident with two acquired pressure areas on her spine does not have pressure risk recorded on her care plan and pressure area cares are not detailed on the long term care plan; one resident with chronic respiratory issues and with an oxygen concentrator, does not respiratory cares recorded on her long term care plan. In summary, in three of five resident files reviewed, interventions required were either not recorded or were not provided – consistent with assessed need and desired outcomes. | Ensure that all resident care requirements are provided and recorded in care plans. | 60 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.8.3 | Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | Short term care plans are not utilised for all short term care issues (or as additions to long term care plan). One resident with a urinary tract infection did not have a short term plan is place; one resident with a wound did not have a short term care plan in place or the LTCP updated (however wound assessment/management plans were in place; and one resident with vaginal bleeding did not have a short term care plan in place. | Ensure that all short term care issues and changes in residents health status are recorded either on a short term care plan or recorded on the long term care plan. | 60 |
| 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 | Advised by the clinical services manager that all medication charts are pre-written for the general practitioner to review and sign. A registered nurse writes the medication orders on to the medication chart for the general practitioner to sign when he/she attends the facility. Advised that this practice is conducted to ensure that charts are clear and legible. | Cease practice of transcribing medication orders on to resident medication charts. | 60 |

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

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

## **Outcome 1.1: Consumer Rights**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident, care/medical issues or complaints arise.  D16.4b Ten family interviews (five rest home and five hospital) stated that they are kept informed when their family members health status changes.  Residents/relatives meetings occur three monthly. A resident survey 2012 has been conducted and results collated identifying a 100% satisfaction overall.  D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. D11.3 The information pack is available in large print and advised that this can be read to residents. |

##### **Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

Consumers have a right to full and frank information and open disclosure from service providers.

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights.  D13.3h. A complaints procedure is provided to residents within the information pack at entry. There was no complaints for 2013 and one complaint for 2012. The complaints register includes follow-up, investigation, letters of any complaints received. Each complaint is signed off following resolution. |

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

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

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

##### **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.

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

## **Outcome 1.2: Organisational Management**

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

#### Standard 1.2.1: 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:** |
| McKenzie Healthcare provides care for up to 55 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 48 residents in total (17 residents at rest home level and 31 residents at hospital level including one resident receiving palliative care).  McKenzie Healthcare is arranged into four wings. On the day of the audit, the 48 residents were located as follows: Scott wing (nine hospital including one palliative care, eight rest home); Moginie wing (twelve hospital, one rest home); Moore wing (five hospital, three rest home); Burton wing (five hospital, five rest home).  A chief executive officer manages the service. A full time clinical services manager (registered nurse); who has been with the service for 28 years manages clinical services. A manager is responsible for the day-to-day management of non-clinical services, human resources & quality. The chief executive officer was not available on the day of the audit. The clinical services manager and human resources/quality manager have all completed at least eight hours of training annually pertaining to the management of a rest home/hospital service. There is business plan 2012-2013 that includes a mission, values, strengths, weaknesses, opportunities, threats, financial goals and business goals. An action plan has been implemented to meet the goals. The stated mission is 'To provide the highest standards of holistic nursing care in a safe and comfortable environment'. A documented philosophy explains how this is achieved in practice. |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| McKenzie Healthcare has a well-established quality and risk management system. The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service has a quality management framework and quality management plan 2013 identifying the quality and risk management system. There are documented goals that align with the identified values and philosophy. The quality management framework states 'McKenzie Healthcare is committed to striving to continuously improve all services and processes that support the care of consumers and the workplace for staff’. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvement.  There is an internal audit schedule and internal audits are completed. Progress with the quality plan is monitored through three monthly quality and risk meetings, monthly health and safety meetings, monthly nursing meetings and monthly healthcare assistant meetings. The quality and risk meeting includes (but is not limited to): internal audits; satisfaction surveys; complaints; incident and accident analysis; infection control analysis; restraint; education. Minutes are maintained and easily available to staff in a folder. Minutes include actions to achieve compliance where relevant. This, together with comprehensive staff training, demonstrates McKenzie Healthcare's commitment to on-going quality improvement. Discussions with registered nurse, activity coordinator, cook and four healthcare assistants (all work across rest home and hospital) confirm their involvement in the quality programme. Incidents, accidents, hazards, complaints, infections and restraint/enablers are monitored through the monthly health and safety meetings and monthly operational/management meetings.  D19.3: There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management policy guides practice. The service has achieved ACC Workplace Safety Tertiary Level for October 2012-September 2014. D19.2g Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, review of medication with GP, hi/lo beds, assessment and exercises by the physiotherapist, and sensor mats.  D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. |

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

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

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

##### **Criterion 1.2.3.3 (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.

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

##### **Criterion 1.2.3.4 (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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. All incidents reviewed (for November 2013) document that family have been informed, there is registered nurse follow up and review of incident. Incident reports were evidenced filed in resident files with appropriate accompanying action plans. The service is benchmarking with five other aged care facilities in Timaru. Comparisons and graphs were available for September and October 2013.  Minutes of the staff meetings and monthly health and safety meetings reflect a discussion of incidents/accidents and actions taken. Ten relatives (five rest home, five hospital) interviewed stated that they are kept fully informed. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. A register of all health professionals practising certificates is maintained. There is an annual education schedule covering core topics and specific topics pertaining to the residents currently residing McKenzie. Records of attendance were evident of attendance and evaluation of each session. External education is available via SCDHB, conferences, seminars and courses. Six staff files were reviewed and all showed evidence of completed orientation booklets, and all six had annual appraisals completed. The staff files reviewed included copies of education and training completed, both internal and external.  D17.7d: Management (clinical service manager and human resources/quality manager) have completed at least eight hours training in relation to management of the service.  There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); syringe driver competency, medication, restraint, PEG tube feeding, wound management, sub cutaneous fluids and CPR/First aid. |

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

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

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

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| **Attainment and Risk:** 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:** FA |
| **Evidence:** |
| There is a staff deployment policy that is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of consumers. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.  The service contracts with allied health professionals on an as required basis.  Interviews with one registered nurse, four healthcare assistants (all work across rest home and hospital), seven residents (four rest home, three hospital) and ten family members (five rest home, five hospital) identify that staffing is adequate to meet the needs of residents.   The clinical services manager works Monday-Friday 07.30-16.30 plus on call every day.   AM Monday-Sunday 1x registered nurse 06.45-15.15 Monday-Sunday 1x healthcare assistant 07.00-15.00; 1x healthcare assistant 07.00-13.00; 1x healthcare assistant 07.00-13.00; 1x healthcare assistant 07.00-15.00; 1x healthcare assistant 07.00-13.00; 1x healthcare assistant 07.00-13.00; 1x healthcare assistant 07.00-15.00.  PM Monday-Sunday 1x registered nurse 14.45-23.00. Monday-Sunday 3x healthcare assistant 15.00-23.00; 1x healthcare assistant 15.00-21.00; 2x healthcare assistant 15.00-20.30.  Night Monday-Sunday 1x registered nurse 22.45-07.00; 2x healthcare assistants 23.00-07.00  Activities Monday-Friday 1x diversional therapist/head of department 08.00-16.30; 2x activity therapists 13-14 hours per week each; 1x casual activities person 6.5 hours per week. There are activities staff on site Monday-Friday 08.00-16.30.  Kitchen Monday-Sunday 1x cook 07.30-13.30; 1x kitchen assistant 09.00-14.00; 1x tea cook 15.30-19.00 Monday-Friday 1x kitchen assistant 17.30-12.00  Laundry/housekeeping Monday-Sunday 1x 08.30-14.00; 1x 07.00-13.00; 1x 08.30-13.00  1x maintenance person is contracted as needed and is on site most days. |

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Care plans are developed and reviewed / evaluated by the clinical services manager and/or registered nurses. Registered nurses complete progress notes on every shift for all residents. Family members are kept informed about the resident's care, confirmed at 10 family interviews (five rest home and five hospital). Seven residents interviewed (four rest home and three hospital) confirm their involvement in the admission process, care planning and evaluation. Clinical staff (one clinical services manager, one registered nurse and four health care assistants) interviewed confirm residents and/or family members are involved in all stages of service provision. All five care plans reviewed (two rest home and three hospital) demonstrate the care plans are developed by the registered nurse, signed off by either the resident or family member.   The previous audit identified that initial assessments and care plans completed by an enrolled nurse were not countersigned by a registered nurse. Two of two files reviewed where the enrolled nurse had completed care planning documentation, a registered nurse had countersigned the entries. The service has made improvements in this area.   Verbal handovers between shifts are conducted, confirmed at staff interviews and observed on audit day. A general practitioner (GP) interview was conducted and confirms staff inform the GP of any medical issues and concerns in timely manner. The GP prescribed treatments are followed by staff.  The clinical services manager and the human resources/quality manager (RN) have completed InterRAI training. Two more RN’s are to complete training in early 2014. None of the five care plans reviewed have been developed using the InterRAI assessment tool and care plan. Risk assessment tools are completed at least six monthly for rest home and hospital residents and include (but not limited to); falls risk, pressure area risk, pain assessments, nutrition assessments, continence assessments, and challenging behaviour assessments. D 16.5ciii: Five of five residents records sampled had initial assessments developed within the required timeframe of 24 hours.  Two rest home resident files sampled included one resident with high falls risk, dementia and referred for reassessment; one resident with chronic obstructive airways disease and with an oxygen concentrator.  Three hospital resident files sampled included one resident on palliative care contract; one resident with an enabler, previous CVA and mobility issues; and one resident with a pressure wound, challenging behaviours, pain issues and on controlled drugs. D16.2, 3, 4: The five files reviewed (two rest home and three hospital), identified that in all five files an assessment was completed within 24 hours and that all five files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by a registered nurse and amended when current health changes. All five long term care plans evidenced evaluations completed at least six monthly for rest home and hospital residents.  D16.5e: Five resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has documented that the resident is stable and can be seen three monthly. Residents are seen more frequently if required.  Tracer methodology – Rest home resident XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  Tracer methodology – Hospital resident 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.

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management training has been completed by two registered nurses and skin and pressure area prevention is to be held in December 2013. Wound assessment and wound management plans are in place for four residents – two with pressure injuries – one acquired from acute care and one small toe pressure area. The clinical services manager and one registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. Residents are assessed by the physiotherapist if required. Mobility aids are made available for residents. Occupational therapist is also available. Six monthly review of care includes resident, family, GP, nursing and care staff and activities staff. A copy of the review letter is sent to family. Referrals and interventions to ensure residents receive appropriate services are discussed, addressed and monitored at this team meeting. Documented interventions were reviewed in five resident care plans. The previous audit identified that pain assessments were not reflected in one resident’s care plan. Five of five resident care plans were reviewed – all have pain assessments conducted if required and care plans for two residents with chronic pain issues have interventions recorded for pain management. The service has made improvements in this respect. However, of the five files reviewed, three residents did not have all required interventions conducted and recorded and this is an area requiring improvement (Noting, two of these had interventions recorded in the progress notes (O2 therapy) and on a wound management assessment and wound management plan: interventions were conducted and recorded for these two, but not on the long term care plan.). |

##### **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:** |
| Documented interventions were reviewed in five resident care plans. The previous audit identified that pain assessments were not reflected in one resident’s care plan. Five of five resident care plans were reviewed – all have pain assessments conducted if required and care plans for two residents with chronic pain issues have interventions recorded for pain management. The service has made improvements in this respect. Care plan intervention pages are available for issues including pain, hygiene, skin integrity, elimination, sensory, mobility, pain, respiratory, restraint, sleep and rest, and behaviours. One resident with chronic respiratory issues and with an oxygen concentrator does not have respiratory cares recorded on the long term care plan. However, there is evidence of the care provided for the resident on oxygen therapy in the progress notes, including oxygen saturation measurement & evaluation. |
| **Finding:** |
| One resident had sustained a head laceration following a fall – neurological observations were not conducted; one resident with two acquired pressure areas on her spine does not have pressure risk recorded on her care plan and pressure area cares are not detailed on the long term care plan; one resident with chronic respiratory issues and with an oxygen concentrator, does not respiratory cares recorded on her long term care plan. In summary, in three of five resident files reviewed, interventions required were either not recorded or were not provided – consistent with assessed need and desired outcomes. |
| **Corrective Action:** |
| Ensure that all resident care requirements are provided and recorded in care plans. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Interview with the activities coordinator confirms that she has been employed at the service for four years and is currently completing diversional therapy training. The activities coordinator is employed for 37 hours each week and is supported by four part time activity assistants. The activities programmes provided at the facility caters to able bodied residents and residents who are unable to attend activities. The activities programme runs from Monday to Friday with occasional weekend activities provided. The activities programme meets the needs of the service group and the service has appropriate equipment. Activities attendance records are maintained and were sighted. Residents, family and staff interviews confirm the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. Residents meetings are held three monthly and have a set agenda that includes but not limited to; food, laundry, and activities. Residents' files sampled demonstrate the individual activities care plans are current and demonstrate support is provided within the areas of leisure and recreation, health and well-being. Goals for individual residents are developed around physical needs, emotional, intellectual, social, spiritual, cultural and sexuality. Monthly progress and evaluations are conducted. The weekly activities programme includes newspaper reading, shopping, entertainment, housie, games, outings in the service van, bowls, happy hour, cares, baking, quizzes, movies, ladies day and blokes day, church services twice a month and one to one activities.  Seven residents and ten family interviewed confirm residents' and their family members' past activities are considered and there is a choice to participate in activities. D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated for rest home and hospital level residents.  D16.3c: All initial care plans were evaluated by an RN within three weeks of admission. All long term care plans are evaluated at least six monthly or earlier if clinical needs change. Risk assessments are evaluated six monthly or earlier should the needs change. All residents' files sampled evidence that evaluations of care plans are within stated timeframes and reviewed more frequently if a resident’s condition changes. The GP reviews residents' medical condition at least three monthly for all residents - one GP is employed as the house doctor and visits once a week. Advised by the GP that residents are seen more frequently than three monthly if required. Medication charts are reviewed three monthly or more frequently as required. (confirmed on GP interview and on 10 medication charts reviewed). Evaluations are conducted by the RNs with input from the resident, family, care givers, and GP. Family are notified of any changes in resident's condition, evidenced in residents' files sampled . Residents and family interviewed confirm their participation in care plan evaluations and this is evidenced in the files reviewed. Residents are reassessed using the service's risk assessment tools. A new care plan is generated if care requirements warrant this. Long term care plans have each aspect of the care plan evaluated and changes are made if required. The service has two staff trained in InterRAI and two RN’s to complete in early 2014. Progress notes are written on every shift for all residents, and detail the resident's progress to meet the goals and objectives of the care plan. Advised that short term care plans are in use for infections (as evidenced in one file) however, short term care plans (or the LTCP updated) were not in use for three residents with short term care issues. This remains an improvement required from the previous audit. |

##### **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.)* |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Residents are reassessed using the service's risk assessment tools. A new care plan is generated if care requirements warrant this. Long term care plans have each aspect of the care plan evaluated and changes are made if required. The service has two staff trained in InterRAI and two RN’s to complete in early 2014. Progress notes are written on every shift for all residents, and detail the resident's progress to meet the goals and objectives of the care plan. Advised that short term care plans are in use for infections (as evidenced in one file). |
| **Finding:** |
| Short term care plans are not utilised for all short term care issues (or as additions to long term care plan). One resident with a urinary tract infection did not have a short term plan is place; one resident with a wound did not have a short term care plan in place or the LTCP updated (however wound assessment/management plans were in place; and one resident with vaginal bleeding did not have a short term care plan in place. |
| **Corrective Action:** |
| Ensure that all short term care issues and changes in residents health status are recorded either on a short term care plan or recorded on the long term care plan. |
| **Timeframe (days):** 60 *(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 service uses individualised medication blister packs. The medications are delivered monthly and checked in by the clinical services manager (registered nurse). Medication charts record prescribed medications, including PRN and short course medications. It was confirmed that transcribing has occurred on all 10 medication charts reviewed. Improvements are required in this area. A staff signature identification sheet is maintained. A registered nurse was observed administering medications to the rest home and hospital residents, and the staff member followed correct administration procedures. Medications and associated documentation is kept on the medication trolley in locked treatment room in the hospital area and in the locked nurses’ station in the rest home area. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts. Controlled drugs are stored in one locked safe inside a locked treatment room in the hospital unit. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly by two staff members. Medication fridge’s are monitored daily and recorded weekly. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos are on all 10 medication charts reviewed. Allergies or nil known allergies are recorded on 10 of 10 medication charts reviewed. Standing orders are current and reviewed and signed off annually by general practitioners who visit the facility.  An annual medication administration competency is completed for registered nurses. Medication training was conducted in July 2013. Registered nurses also completed two yearly syringe driver competencies. There is a self-medicating resident’s policy in place. A self-medication assessment checklist is available. There are currently no residents who self-administer medications. Individually prescribed resident medication charts are in use and this provides a record of medication administration information that complies with relevant recording requirements. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated and c) able to meet acceptable good practice standards. As required (PRN) medication orders all record indications for use. D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. |

##### **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:** |
| Medication charts record prescribed medications, including PRN and short course medications. A registered nurse was observed administering medications to the rest home and hospital residents, and the staff member followed correct administration procedures. Medications and associated documentation is kept on a medication trolley in locked treatment room in the hospital area and in the locked nurses’ station in the rest home area. Medications are reviewed three monthly with medical reviews by the attending GP. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts. Controlled drugs are stored in one locked safe inside a locked treatment room in the hospital unit. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Two staff members check controlled drugs weekly. Medication fridge’s are monitored daily and recorded weekly. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Resident photos are on all 10 drug charts reviewed. Allergies or nil known allergies are recorded on 10 of 10 medication charts reviewed. |
| **Finding:** |
| Advised by the clinical services manager that all medication charts are pre-written for the general practitioner to review and sign. A registered nurse writes the medication orders on to the medication chart for the general practitioner to sign when he/she attends the facility. Advised that this practice is conducted to ensure that charts are clear and legible. |
| **Corrective Action:** |
| Cease practice of transcribing medication orders on to resident medication charts. |
| **Timeframe (days):** 60 *(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:** FA |
| **Evidence:** |
| All kitchen staff have completed food safety certificates (NZQA). The service has a large workable kitchen that contains a walk-in chiller, a freezer and a pantry. The menu is designed and reviewed by a registered dietitian (last conducted June 2011). Advised that the kitchen service is being contracted out – the new nation wide contractors take over in January 2014. The new food service provider will have a menu developed for the service. There is a five weekly winter and summer menu. Food is prepared and cooked in the kitchen and delivered to the three dining areas for serving. Food is plated and trayed and stored in hot boxes for delivery to the end hospital dining room, and is served from trolleys and bain maries to the hospital and rest home dining area. Advised by the cook that modified diets are catered to: diabetic, low residue, pureed, soft and any allergies or likes and dislikes are catered to.  Kitchen staff were observed wearing head covering and gloves while serving food. Staff were observed assisting residents with their lunch time meals and drinks. Kitchen fridge, food and freezer temperatures are monitored and documented daily and weekly. There is a food service manual and cleaning schedules. Food in fridges, freezer and pantry are labelled and dated. Decanted food is dated and time for rotation is recorded. Cleaning schedules are implemented.  Nutritional assessments are conducted on all residents and the kitchen staff are informed of dietary requirements. Nutritional assessments are reviewed six monthly as part of the care plan review. Changes to residents dietary needs are communicated to the kitchen. Special diets and resident likes/dislikes are noted on the whiteboards which are able to be viewed only by kitchen staff. Supplements are provided to residents with identified need. |

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

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

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

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

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

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

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

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

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

## **Outcome 1.4: Safe and Appropriate Environment**

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The service displays a current building warrant of fitness, which expires on 1 July 2014. |

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

All buildings, plant, and equipment comply with legislation.

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

##### **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.)* |

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

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

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| **Attainment and Risk:** FA |
| **Evidence:** |
| McKenzie Healthcare is committed to restraint minimisation and the use of restraint as a last resort. There are currently no residents using restraint and ten residents with enablers. The service has maintained restraint free since June 2012.  Restraint minimisation and safe practice policy and procedure includes definitions of restraint, assessment, safe restraint use, emergency restraint, safe enabler use including consent, evaluation, categories of restraint; types of restraint and approved restraints and enablers (tray chairs, lap belts, bed rails, fall out chairs). Related forms include: assessment for restraint, consent form, restraint/enabler care plan which covers category of restraint and clinical indicators, monitoring guidelines and evaluations. Advised by the restraint coordinator (clinical services manager) that restraint is used as a last resort when all other interventions have been tried and proven unsuccessful. The service philosophy is to ensure the physical safety and wellbeing of the resident, and minimise adverse events for residents.  There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There is a restraint approval group that reports monthly to the quality and risk meeting. Restraint minimisation, challenging behaviour and de-escalation in-service has been provided to staff 15 March 2013.  Restraint audit occurred- April 2013. |

##### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

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

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| **Attainment and Risk:** 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 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The surveillance policy includes the routine/planned surveillance programme. The infection control nurse reports to the clinical services manager and provides monthly reports to the quality meeting and three monthly reports to the quality and risk committee. Effective monitoring is the responsibility of the infection control nurse. Surveillance includes audits of the facility, hand washing and surveillance of infection control events and infections. There is an infection control register in which includes documentation of all infections based on signs and symptoms rather than prescribed antibiotics. A previous shortfall in regards to recording of all infections is now met by the service. A monthly and annual report is completed. The infection control manual includes definitions of common infections. There is evidence of the use of short term care plans to manage and monitor those residents with infections. The surveillance activities at McKenzie Healthcare are appropriate for the size and complexity of the facility and are described in the surveillance policy. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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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 3.5.7 (HDS(IPC)S.2008:3.5.7)**

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

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