

Benhaven Care Limited

Current Status: 8 November 2013

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

General overview

Benhaven rest home provides rest home and residential disability level care for up to 19 residents. On the day of the audit, there were 17 residents (13 rest home residents and four young disabled residents). The current owners have owned the facility since July 2013 and the previous management team continues to work with the new owners. There is a contract in place for the previous owners for one year effective from July 2013, to act in the role of aged residential care/quality consultants to the current owners.

The service has addressed the three shortfalls from their previous provisional audit.

This audit identified further improvements required around essential notifications, implementation of risk management plan and medical admission timeframes.

Audit Summary as at 8 November 2013

Standards have been assessed and summarised below:

Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	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 8 November 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Organisational Management as at 8 November 2013

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Continuum of Service Delivery as at 8 November 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Safe and Appropriate Environment as at 8 November 2013

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.
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Restraint Minimisation and Safe Practice as at 8 November 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 8 November 2013

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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HealthCERT Aged Residential Care Audit Report (version 3.91)

Introduction

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

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

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

Audit Report

Legal entity name:	Benhaven Care Limited		
Certificate name:	Benhaven Rest Home		
Designated Auditing Agency:	HDANZ		
Types of audit:	Surveillance		
Premises audited:	Benhaven Rest Home		
Services audited:	Rest Home, disability - physical		
Dates of audit:	Start date: 8 November 2013	End date: 8 November 2013	
Proposed changes to current services (if any):			

Total beds occupied across all premises included in the audit on the first day of the audit:	17
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Audit Team

Lead Auditor	XXXXX	Hours on site	7	Hours off site	5
Other Auditors	XXXXX	Total hours on site	7	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

Sample Totals

Total audit hours on site	14	Total audit hours off site	10	Total audit hours	24
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Number of residents interviewed	5	Number of staff interviewed	5	Number of managers interviewed	1
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	10	Total number of staff (headcount)	14	Number of relatives interviewed	1
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:

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

Dated Tuesday, 14 January 2014

Executive Summary of Audit

General Overview

Benhaven rest home provides rest home and residential disability level care for up to 19 residents. On the day of the audit, there were 17 residents (13 rest home residents and four young disabled residents). The current owners have owned the facility since July 2013 and the previous management team continues to work with the new owners. There is a contract in place for the previous owners for one year effective from July 2013, to act in the role of aged residential care/quality consultants to the current owners. The service has addressed the three shortfalls from their previous provisional audit. This audit identified further improvements required around essential notifications, implementation of risk management plan and medical admission timeframes.

Outcome 1.1: Consumer Rights

There is an open disclosure policy, which describes ways that information is provided to residents, and families/representatives at entry to the service continually and as required. Residents and family are involved in the initial care planning and receive and provide on-going feedback. Regular contact is maintained with family including if an incident/ accident or a change in residents health status occurs. The service has documented complaints and there is evidence of follow up. The previous audit identified that advance directives were not correctly completed. A review of advance directives evidenced that this shortfall has been addressed.

Outcome 1.2: Organisational Management

The facility has two owners who have owned the facility since July 2013. They are supported by a manager (enrolled nurse) and a registered nurse. The owners have contracted an aged care/quality consultant to mentor and provide support to them during their first year as owners of an aged care facility. Benhaven has a quality and risk management plan in place with annual quality activities conducted. A quality and risk management meeting is held to report and discuss quality and resident issues. Internal audits are conducted. Corrective actions are developed following quality activities to ensure identified issues are followed through. Incidents and accidents, and infection rates are reported with an analysis completed monthly. Incident and accidents are followed up from the registered nurse and appropriate clinical management is provided. Residents and relative interviewed confirmed they are kept fully informed of adverse events as per the open disclosure policy. There are human resource policies and procedures in place. In-service training is provided in addition to the aged care education programme (ACE). Rosters are in place. The manager (enrolled nurse) and registered nurse provide on call service after hours. The roster provides sufficient and appropriate coverage for effective delivery of care and support for the facility.

Outcome 1.3: Continuum of Service Delivery

Each stage of service provision is carried out by an experienced registered nurse (RN) who is competent to perform this role. Cares and support are primarily provided by health care assistants under the supervision of the RN. An assessment was completed within 24 hours and 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 RN and amended when current health changes. All care plans evidenced evaluations completed at least six monthly and on-going nursing evaluations occur daily as indicated and are included in the progress notes. A corrective action required from the previous audit around resident's weight monitoring has been addressed, however this audit identified further improvements required around implementation of risk management plan and medical admission timeframes.

Activities programme has changed since the previous audit and Benhaven is in progress of employing a diversional therapist. Attendance is recorded and resident files include review of the activities plan. Activities programme is also provided by the caregivers and staff are aware of resident's recreational needs. There are suitable activities available for residents under the age of 65 with trips to the movies, cafes, concerts, social events and entertainment.

Medication management is appropriately managed in line with accepted guidelines. All medicines are reviewed by the GP three monthly and staff who administer medicines have been assessed as competent to do so. A corrective action required around documentation of administration of controlled drugs from the previous audit has been addressed.

Benhaven employs two cooks who cover seven days a week. There is a rotating three weekly summer and winter menu in place. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Special equipment is available as needed. Residents are offered fluids throughout the day and additional snacks are available for residents such as sandwiches, biscuits and bread. Residents interviewed reported satisfaction with the food service.

Outcome 1.4: Safe and Appropriate Environment

Benhaven Rest Home has a current building warrant of fitness that is dated 4 October 2013 and valid for 12 months. The maintenance person works two hours a day Monday to Friday and undertakes reactive and preventative maintenance. A corrective action from the previous audit around annual check of hoists has been completed.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint policy that includes definitions of restraint and enablers. There are three residents requiring the use of enablers (bed rails and lap belt). The enabler use is documented in resident care plans and review of the need for an enabler occurs six monthly at care plan review. Staff are trained in restraint minimisation and managing challenging behaviours.

Outcome 3: Infection Prevention and Control

Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	14	0	0	3	0	0
Criteria	0	39	0	0	3	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	33
Criteria	0	0	0	0	0	0	0	59

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.4: Adverse Event Reporting	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.	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Criterion 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.	PA Moderate	An Incident form reviewed for 08-Oct-13 documented that the police were contacted regarding a resident who had gone missing from the premises. The manager advises that the DHB or MOH were not informed regarding this incident.	Ensure that the relevant authorities are contacted regarding essential notification.	90
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Three of four files reviewed showed that the medical assessment on entry to the service was not completed within two working days of admission. It was noted that the GP has seen the resident between five to 10 days. The GP visits Benhaven weekly on Tuesday's and this includes a medical assessment of new	Ensure that GP has seen a resident within two working days of admission.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				admissions to the service. The RN stated that she was not aware of this requirement therefore, additional GP visits were not scheduled for new admissions to Benhaven.		
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	Incident accident forms reviewed indicate that activities hours are required to be reviewed. This is indicated under "follow up action" on the incident accident forms; however this has not been implemented yet. It appears that there is no alternative risk management plan in place related to required interventions, for example de-escalation, except that the staff should	Ensure that a risk management interventions related to de-escalation is implemented.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>ensure regular checking of the resident. Staff interviewed stated that they are unable to monitor the resident at all times. Discussions with the manager and the RN confirms that referral for re assessment, for possible transfer to dementia level service due to wandering, has not been considered. They feel that this will not be an appropriate level of care for the resident.</p> <p>Although wandering is identified, required actions are not implemented. The manager and the RN acknowledged that activities reduce anxiety, agitation, restlessness and wandering, however due to the resignation of activities coordinator, the required interventions will only be implemented</p>		

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				following a new recruitment.		

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: FA

Evidence:

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 Benhaven rest home information booklet is provided to residents on entry and this comprehensively includes information around rights, complaints, abuse and neglect etc.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b One relative interviewed states that they are always informed when their family members health status changes and the seven incident forms reviewed for October 2013 indicate that family are informed and if not, the reason is noted.

D11.3 The information pack is available in large print and advised that this can be read to residents. The service has policies and procedures available for access to interpreter services noting that there are no residents requiring interpreting services.

There is an open disclosure policy, a complaints policy and an incident and accident policy and staff have had training around the code of rights including advocacy and open disclosure in May 2013.

Resident who do not have family have the name and contact details of their advocate documented in their file.

Five residents and one family member interviewed state they were welcomed on entry and were given time and explanation about services and procedures.

Resident meetings occur three monthly and family are invited to this. The manager has an open-door policy that she is able to describe.

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: FA

Evidence:

The previous audit identified that resuscitation/advance directive forms were not completed correctly. The service since June 2013 is utilizing the HVDHB resuscitation/advance directive form. Five resident files reviewed evidenced that resuscitation/advance directive forms were correctly completed. Education for staff on advance directives occurred 24-Oct-13.

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

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

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

Attainment and Risk: FA

Evidence:

The service has complaints management policies and procedures in place.

D13.3h. A complaints procedure is provided to residents and their family within the information pack at entry.

Complaint forms are available at the entrance to the building. Staff are aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family.

Five of five residents and one family member interviewed confirm they are aware of the complaints process and they would make a complaint to the manager of other staff if necessary.

There is a complaints register in place. A complaints folder is maintained with the documentation related to each complaint including sign-off of the complaint.

There have been two complaints received in 2013. One was received at the end of October 2013 and evidence that an investigation has occurred. The manager is awaiting confirmation of resolution to the complainant's satisfaction.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(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.

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

Outcome 1.2: Organisational Management

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

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

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

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA
Evidence: Benhaven's organizational structure includes two (non-clinical) owners, a full time manager who is an enrolled nurse (with current APC) and a registered nurse (with current APC) who works 17 hours over three days per week. The owners have owned Benhaven since July 2013, and the manager has been in place for 10 years. In the absence of the manager, the registered nurse (with support of the owners) provides cover. One of the owners has a Master's degree in Business Administration and a BA in English Language and Literature the other owner has a law degree. Both owners live on site. There is a contract in place for the previous owners for one year effective from July 2013, to act in the role of aged residential care/quality consultants to the current owners. The aged care consultants visit weekly and can be contacted by telephone at any time if needed. ARC,D17.3di (rest home): The manager has maintained professional development activities related to managing a rest home. Benhaven has quality objectives that are monitored through monthly trending of incident reporting. There is a process for managing shortfalls through

Corrective Action Request forms (sighted) that include evaluation for effectiveness and close out. Monitoring against objectives is discussed at staff meetings (held three monthly).

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

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

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

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a business risk assessment and management plan and this includes a quality plan. The service has in place a range of policies and procedures to support service delivery that are reviewed regularly. Quality data is collected and evaluated and used for quality improvement. Key components of the quality system link to service delivery. Corrective actions are documented against identified issues as these occur through internal audits, complaints and review of incident and accidents.

There is a document control system. All policies include the date the policy was last reviewed and a review date noting that policies have been reviewed last in December 2012 to March 2013. Documents no longer relevant to the service are removed and archived. Discussion with the two caregivers, the enrolled nurse (manager), the registered nurse, the activities coordinator and cook identified that staff are familiar with the policies and procedures. There are implemented health and safety policies that include hazard identification. There is a quarterly staff meeting, which includes health and safety and OSH, monitoring of hazards, and risks. There is a proactive maintenance schedule implemented and issues are managed promptly as these arise. The maintenance person works two hours per day Monday to Friday. A review of the documentation indicates that maintenance issues and hazards are resolved promptly.

Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There are infection control policies and procedure, a restraint policy and health and safety policies and procedures.

D19.2g: Falls prevention strategies are in place that include the analysis of falls incidents, sensor mats for relevant residents, increased supervision if required for a resident identified as a high falls risk and the identification of interventions on a case by case basis to minimise future falls. An exercise class is part of the activities programme.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>
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Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

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

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: <p>There is an open disclosure policy and family members interviewed stated they are informed of changes in health status. Training for staff around open disclosure was last held in February 2013. Seven incident/accident forms reviewed for October 2013 document whether or not family have been informed and all indicate that family are kept informed appropriately.</p> <p>The two caregivers, the manager, activities coordinator, cook and the registered nurse (RN) interviewed are all familiar with the incident/accident reporting process and describe discussion of these at the staff meeting. There is an improvement required regarding essential notification to relevant authorities.</p>

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

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

Attainment and Risk: PA Moderate
Evidence: The manager when interviewed was unaware of the need to contact the relevant authorities regarding essential notification. (link to 1.3.3)
Finding: An Incident form reviewed for 08-Oct-13 documented that the police were contacted regarding a resident who had gone missing from the premises. The manager advises that the DHB or MOH were not informed regarding this incident.
Corrective Action: Ensure that the relevant authorities are contacted regarding essential notification.
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Human resources policies are implemented. An orientation programme is in place that includes the assessment of initial medication competencies if relevant for the staff member and sign off included in five files reviewed. The two caregivers could describe the orientation training. The caregivers state that the orientation includes reading of all policies and procedures and buddying with a caregiver for at least two days. There is a very low turnover of staff and a new staff member is always rostered on with another staff member. On review of the five staff files, performance appraisals have been conducted in 2013, all five files had signed position descriptions and reference checks are documented. One of the five files have police checks completed noting that the others are staff who have been in the service for a long time.

An annual in-service education programme is in place. The annual training plan covers a range of subjects and attendance at these is recorded on staff records. Discussions with the two caregivers, the enrolled nurse, the registered nurse and manager 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 staff related to medication with all relevant caregivers, enrolled nurse and the registered nurse completing these annually.

The registered nurse and enrolled nurse have a current practicing certificate - sighted.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staffing is as follows: two caregivers in the morning and afternoon shifts. The night caregiver works from midnight to 0900 and this includes support for showering and feeding residents. The manager (enrolled nurse) works from 7.45 to 4pm five days per week and a registered nurse who works 17 hours a week over three days. The activities coordinator works a total of 15 hours per week, which is split over mornings and afternoons. The service does not use agency staff and all leave is covered in the rosters reviewed. The GP interviewed confirmed that staffing is appropriate to meet the needs of residents. Five residents and one family member interviewed state that there are sufficient staff on duty at all times.</p>

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

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

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: Four rest home and one YPD file are reviewed. D16.2, 3, 4. Review of four rest home files revealed that each stage of service provision (assessment, planning, provision, evaluation, review and exit) has been provided within stated timeframes, except medical assessment on entry to the service was not completed within two working days of admission. An assessment was completed within 24 hours and all four files identify that the long-term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by an RN and amended when current health changes. All care plans evidenced evaluations completed at least six monthly.

Three monthly medication reviews by a general practitioner (GP) are documented on the residents' file. A range of assessment tools were completed in resident files on admission and completed at least six monthly

Each stage of service provision is carried out by an experienced RN who is competent to perform this role. Cares and support are primarily provided by health care assistants under the supervision of the RN. There is an in-service programme for all staff.

All staff, the GP and other health professionals document notes in the resident file. Two caregivers and the RN interviewed report a thorough handover and use of the communication book to ensure continuity of service delivery. Specialist input is obtained as required, this was evidenced in one of the files reviewed. Five residents are interviewed(one YPD and four rest home), and they all stated that they have input into their care.

Verbal handover is undertaken between shifts and any changes to resident's condition is documented. Document review confirms that services are coordinated to promote continuity in service delivery.

The previous audit identified that there were no suitable weigh scales available to weigh two residents monthly and there was no documentation in the medical notes to determine the frequency of weight recording. Since the previous audit, these residents have been reviewed by the GP and documented in the medical notes that there is 'no need for weighing but to be observed'. The RN and the manager interviewed stated that these residents are observed and there is no indication of weight lost or weight gain. Document review confirmed that residents' weights are monitored monthly except those who were identified by the GPs no weighing required. Discussion with the manager and the RN confirmed that they can access a rental scale if required. Therefore, the corrective action required from the previous audit has been addressed.

Tracer methodology 1

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

Tracer methodology 2

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Four rest home files reviewed showed that the RN completes an initial assessment within 24 hours of admission and the long-term care plan was completed within three weeks. There is documented evidence that the care plans were reviewed by the RN and amended when current health changes. All four care plans evidenced evaluations completed at least six monthly. Short-term care plans are used for short-term needs.

Finding:

Three of four files reviewed showed that the medical assessment on entry to the service was not completed within two working days of admission. It was noted that the GP has seen the resident between five to 10 days. The GP visits Benhaven weekly on Tuesday's and this includes a medical assessment of new admissions to the service. The RN stated that she was not aware of this requirement therefore, additional GP visits were not scheduled for new admissions to Benhaven.

Corrective Action:

Ensure that GP has seen a resident within two working days of admission.

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

Attainment and Risk: PA Moderate
<p>Evidence:</p> <p>Residents' care plans are completed by the RN in conjunction with input from caregivers, the GP, residents and family members. The care plans record appropriate interventions based on the assessed needs, desired outcomes or goals of the residents. The required clinical care/treatment is recorded. Weights are recorded on a monthly basis with the exception of three files that the GP noted, "no weighing required".</p> <p>D18.3 and 4 Dressing supplies are available and a stock of supply is available. On the day of audit, there is no resident requiring wound care.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management. Continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.</p> <p>Five residents (one YPD and four rest home) and one rest home family member are interviewed and they are all complimentary of the care provided at Benhaven. Staff are considerate of residents' needs as observed by both auditors on the day of audit. However, one of the files (YPD) identified that the risk management plan around management of a challenging behaviour is not managed well.</p>

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

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

Attainment and Risk: PA Moderate
<p>Evidence:</p> <p>Care plans reviewed (four rest home) are up to date and describe interventions consistent with meeting resident's assessed needs and desired outcomes. Two caregivers and the RN interviewed are knowledgeable of resident's current needs and they could elaborate on appropriate interventions for each resident. When residents' condition alters, the RN initiates a review and if required GP or specialist consultation.</p>

Mobility aids required to meet the mobility needs and safety of residents are available. The RN advised that there are four residents under YPD contract and required equipment and resources are provided through Rehab rental.

Finding:

Incident accident forms reviewed indicate that activities hours are required to be reviewed. This is indicated under “follow up action” on the incident accident forms, however this has not been implemented yet. It appears that there is no alternative risk management plan in place related to required interventions, for example de-escalation, except that the staff should ensure regular checking of the resident. Staff interviewed stated that they are unable to monitor the resident at all times. Discussions with the manager and the RN confirms that referral for re assessment, for possible transfer to dementia level service due to wandering, has not been considered. They feel that this will not be an appropriate level of care for the resident. Although wandering is identified, required actions are not implemented. The manager and the RN acknowledged that activities reduce anxiety, agitation, restlessness and wandering, however due to the resignation of activities coordinator, the required interventions will only be implemented following a new recruitment.

Corrective Action:

Ensure that a risk management interventions related to de-escalation is implemented.

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

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

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

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

Attainment and Risk: FA

Evidence:

Activities hours changed since the previous audit. The manager stated that when occupancy level had dropped, as a consequences activities hours were re adjusted and dropped to 15 hours a week. The program was provided by the two activities coordinators and one had already resigned and the other activities coordinator had also accepted another position and currently is completing her notice period. The new owner and the RN stated that new recruitment of a diversional therapist is in progress.

Daily activity plan is displayed on the white board and residents participate in outings. Attendance is recorded and resident files include review of the activities plan. Activities program is also provided by the caregivers and staff are aware of resident’s recreational needs. There are suitable activities available for residents under the age of 65 with trips to the movies, cafes, concerts, social events and entertainment.

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>D16.4a . Review of four rest home files identified that care plans are evaluated by the RN at least six monthly and more frequently when clinically indicated. There is at least a three monthly review by the medical practitioner including medication reviews. On-going nursing evaluations occur daily as indicated and are included in the progress notes.</p> <p>Residents whose condition changed, were assessed by the RN, GP and if required were transferred to the local hospital for treatment. On the day of audit, one of the rest home residents' lab results showed infection and the RN contacted the GP and subsequently antibiotic treatment commenced. One other rest home resident file evidenced short term care planning in management and prevention of UTIs. Review of one of the rest home file also evidenced changes to care plans around pain management. Medication review showed use of PRN (as required) medication as indicated by the RN and ongoing review of pain management plan is documented in the progress notes and interventions are regularly updated. The RN stated that should a resident not respond to current interventions delivered or their health status changes then this is discussed with the GP immediately. GP interview also confirmed appropriate and timely referrals from the RN and the manager.</p>

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

10 medication charts were reviewed and all comply with current legislative requirements. Benhaven uses the medication management system of robotic sachets and checked by the RN on arrival. Discrepancies are reported to the pharmacy and all returns to the pharmacy drugs are quarantined from the main supply and held in the separate box until returned. All drugs are kept in a locked room. All medication charts are legible and reviewed three monthly. Controlled drugs are stored in a locked cupboard and stock takes occur. The RN and medicine competent caregivers administer medicines. Staff who administer medicine maintain current competency. On the day of audit, there are no residents at Benhaven self-administering medications. Medication charts have photo identification and allergies are documented.

The RN completes monthly medication documentation audits and outcome of the audit is communicated to staff and an informal staff training occurs as needed. Staff interview also confirmed that this occurs.

There was a corrective action required from the previous audit around documentation of administration of controlled drugs, this has been actioned. The controlled drug administration documentation includes two staff signatures and staff members who also check and witness the administration of controlled drugs. There is only one resident who requires the use of controlled drugs on the day of the audit and review of the controlled drug register is found to be correct.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Benhaven has a small domestic style kitchen next to the dining room. Food is directly served from the kitchen and residents can have a meal in their rooms if they desire. The kitchen and equipment is maintained in a clean manner. Benhaven employs two cooks who covers seven days a week. There is a rotating three weekly summer and winter menu in place. Resident's individual dietary needs are identified, documented and reviewed on a regular basis. Residents special dietary needs are written on the white board and likes and dislikes are catered for. Special equipment is available as needed. Residents are offered fluids throughout the day and additional snacks are available for residents such as sandwiches, biscuits and bread. Residents files sampled demonstrate regular monitoring of individual resident's weight and nutritional needs except the residents have been reviewed by the GP and documented in the medical notes that there is no need for weighing but to be observed. Residents (one YPD and four rest home) interviewed were very complimentary of the food service provided and report their individual preferences are well catered for. One of the resident interviewed stated that she only eats organic food, plenty of fish and vegetables. She purchases some of her food and staff prepares and serves it to her.</p>

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: The facility complies with all applicable legislation codes, standards and regulations. Benhaven has a current building warrant of fitness that is dated 4 October 2013 and valid for 12 months. The maintenance person works two hours a day Monday to Friday and undertakes reactive and preventative maintenance. Since the provisional audit, both hoists are checked and tagged indicating safe for use. The manager interviewed stated that this will be checked yearly, therefore the corrective action required from the previous audit has been implemented. On interview, the owner and the manager stated that they have ordered new equipment including hospital beds, a weighing scale, mattresses, sense mats and shower chairs and they expected to be delivered within three weeks.

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: Documented systems are in place to ensure the use of restraint is actively minimized. The registered nurse is the restraint coordinator. There are currently three residents using enablers, two bedrails and one lap belt. Staff interviews and staff records evidence guidance has been given on restraint minimization

and enabler usage. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on challenging behaviour management and restraint minimization was conducted on 07-Mar-13 with seven staff attending. Enablers are monitored when in use, and use of enablers is evidenced documented in resident's care plans. Evaluation of the need for enabler use is reviewed at six monthly care plan review.

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected, collated and analysed to identify areas for improvement or corrective action requirements. Trends are analysed and discussed at quarterly staff meetings.

Detailed information on the type of infections, treatment, duration of treatment and its effectiveness are recorded. Resident's infection trends/patterns are identified and recorded. Any corrective actions are acted upon as sighted in the meeting minutes.

An annual review of infection control occurs and was last completed December 2012.

Education on infection control for staff was completed in May 2013. An infection control audit was completed in July 2013 with no corrective actions required.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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