# Eastcliffe Orakei Management Services LP

## Current Status: 15 January 2014

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

## General overview

Eastcliffe on Orakei is a care facility within the environment of a retirement village. The Unit has 28 beds, 10 of which are for hospital residents and 18 of which can be used for either hospital or rest home residents. This unannounced surveillance audit was undertaken to verify compliance with selected requirements of the Health and Disability Standards and the District Health Board contract. All improvements required at the certification audit in February 2013 have been addressed. Three improvements are required following this audit in relation to appropriate assessments of residents following a fall, medication management and medication administration.

## Audit Summary as at 15 January 2014

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | 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 15 January 2014

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

### Organisational Management as at 15 January 2014

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

### Continuum of Service Delivery as at 15 January 2014

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

### Safe and Appropriate Environment as at 15 January 2014

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

### Restraint Minimisation and Safe Practice as at 15 January 2014

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

### Infection Prevention and Control as at 15 January 2014

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

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

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

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

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

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Eastcliffe Orakei Management Services LP |
| **Certificate name:** | Eastcliffe Orakei Management Services LP |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | Health Audit (NZ) Limited |

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Eastcliffe on Orakei |
| **Services audited:** | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 15 January 2014 | **End date:** | 15 January 2014 |

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

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 25 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 4 |
| **Other Auditors** | XXXXX | **Total hours on site** | 8 | **Total hours off site** | 3 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 9 | Total audit hours | 25 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 2 | Number of staff interviewed | 3 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 4 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 22 | Number of relatives interviewed |  |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

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

I confirm that:

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

Dated Tuesday, 28 January 2014

## **Executive Summary of Audit**

|  |
| --- |
| **General Overview** |
| Eastcliffe on Orakei is a care facility within the environment of a retirement village. The Unit has 28 beds, 10 of which are for hospital residents and 18 of which can be used for either hospital or rest home residents. On the day of audit there were 26 residents (10 hospital level residents and 16 rest home residents). This unannounced surveillance audit was undertaken to verify compliance with selected requirements of the Health and Disability Standards and the District Health Board contract. All improvements required at the last audit in February 2013 have been addressed. Three improvements are required following this audit in relation to appropriate assessments of residents following a fall, medication management and medication administration. |

|  |
| --- |
| **Outcome 1.1: Consumer Rights** |
| The facility implements policy to ensure residents and family/whānau are kept informed as appropriate. Family/whānau communication is well documented in residents' files.The complaints management system is readily accessible and managed and documented in compliance with the Code of Rights. There has been one complaint from the Health And Disability Commission that is currently being investigated. |

|  |
| --- |
| **Outcome 1.2: Organisational Management** |
| There is sound operational management. The quality and risk management system is established and maintained and improvements implemented whenever practicable. Adverse events are recorded and actions taken to prevent recurrence. Improvement is required to ensure that all residents who have unwitnessed falls have a neurological assessment. An effective health and safety and hazard management system is in place. The organization has excellent human resource management and very stable staff. Staff training is maintained in accord with contract requirements. Staffing numbers and skill mix are suitable for the layout of the facility, and for the complexity and numbers of residents accommodated.  |

|  |
| --- |
| **Outcome 1.3: Continuum of Service Delivery** |
| Care and support is provided by a range of health professionals. Clear time frames for service provision are defined and monitored. Lifestyle plans and interventions are current and sufficiently detailed to meet the health and wellbeing needs of residents. The previous area of improvement regarding the development of short term plans has been adequately addressed.Activities are planned to meet the needs of the resident. Individual activity goals are documented and ensure the provision of relevant and appropriate activities are provided. Previous interests, hobbies, culture and ability is considered. Sufficient activities and outings are provided and participation in activities is voluntary.An appropriate medication management system is in place. The required policies and procedures are documented and available to staff. All medications are stored securely. Medications are monitored by the registered nurses and the GP. The previous opportunities for improvement regarding prescribing and administration records have been adequately addressed; however an additional improvement is identified during the auditor observation of a medication round. The provider is also required to update the standing order for oxygen to ensure it meets the 2012 Standing Orders guidelines.Food services are provided by an external provider. Food and nutritional needs of residents are assessed and the menu is reviewed by a dietician. Special needs are catered for and monitored. Food preparation and storage meets food safety requirements. |

|  |
| --- |
| **Outcome 1.4: Safe and Appropriate Environment** |
| The building has a current warrant of fitness. There have been no alterations to the building since the last audit. The facility and equipment are well maintained and safe for residents. Safe external areas are easily accessible. Previous improvements required in relation to training staff in the management of waste, and hazardous substances, monitoring of laundry machine temperatures, annual electrical safety checks and ensuring that all staff attend a fire training annually have all been effectively addressed.  |

|  |
| --- |
| **Outcome 2: Restraint Minimisation and Safe Practice** |
| There are adequately documented guidelines on the use of restraints and enablers. The previously identified opportunities for improvement regarding restraint and enabler definitions and monitoring have been adequately addressed. Alternatives to restraint are in use. There is currently one resident with bed rails in place and these are being used safely. All staff receive sufficient training on restraint and enabler use.  |

|  |
| --- |
| **Outcome 3: Infection Prevention and Control** |
| The infection control programme is clearly documented and is suitable for a hospital/rest home setting. The infection surveillance program is appropriate for the facility and the level of care provided. Infection data is analysed for trends and communicated to staff. The use of antibiotics is monitored. There have been no infection issues or out breaks since the last audit. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 17 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 1 | 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 | 31 |
| **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 Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.4.3 | The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Neurological assessments are not consistently done following a resident fall. | Consistently conduct and document neurological assessments following a resident fall. | 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 Low | The medication policy makes reference standing orders for the use of oxygen; however this is yet to be documented in manner which complies with the 2012 Standing Orders guidelines. | Fully document the standing order for the use of oxygen in line with the 2012 Standing Orders Guidelines. | 180 |
| HDS(C)S.2008 | Criterion 1.3.12.3 | Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Medication administration observed during the audit did not meet best practice and there is no process for reviewing the competency path of nurses following a medication error. | Review competencies for registered nurses administering medication. | 60 |

## **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:** |
| Documented open disclosure policy is in accord with the Health & Disability Commission (HDC) guidelines. Nurse Manager interviewed and aware of open disclosure requirements. Disclosure to resident/family of untoward events is recorded on incident forms and in the resident's file (Sighted in three of three samples). Advocates are available if requested and privacy for interviews is assured in individual resident rooms. The Auckland District Health Board (ADHB) interpreter service is contacted if interpretation cannot be provided by a family member or a staff member. Current staff speak six languages between them. Current residents all speak good English. Relevant Age Related Care (ARC) contract requirements are met. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Complaints process is included in the Resident Information Pack. The process and forms are openly available at each nurse’s station. Process and time frames are in accord with Right 10 of the Code. Two residents interviewed are aware of their right to complain and how to do so.A Complaints Register and associated records are maintained. There have been seven complaints in the last 12 months, including one to the Health and Disability Commissioner. Records provide evidence that the complaints process has been followed in accord with required time frames, appropriate remedial actions taken, and a satisfactory resolution achieved in all cases except the one to the Commissioner that is still under review. Relevant ARC requirements are met |

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(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:** |
| Business Plan Eastcliffe on Orakei 2013 defines philosophy, values, goals and objectives for quality improvement, contractual and legislative compliance, business, staff development, facility development. The Nurse Manager (NM) and senior staff meet annually to review the Business Plan, including assessment of progress towards achieving the goals and objectives. The manager's job description identifies the experience, responsibility and authority required for the role. Nurse Manager interview and review of NM personnel records confirm that the description is current and NM qualifications and experience are appropriate for the role. There is evidence on file that NM has completed more than 20 hours of relevant clinical and management education on the last 12 months.Relevant ARC requirements are met. |

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(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.

|  |
| --- |
| **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 1.2.3: 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:** |
| Documented quality and risk management plans are in place that are relevant to the facility and the level of services provided. The Quality Action Plan is reviewed annually, last done May 2013.There are relevant management and service delivery policies in place that are based on good practice principles. Visual inspection and staff interview confirm that relevant policies, procedures and guidelines are provided in each work area for staff reference. The document control process includes minimum biennial review of policies and procedures. Issue and review dates, issuer and approver are identified on each document. Staff read and sign new / changed documents. Obsolete documents are marked “Obsolete”, removed to a review folder and then archived. There is an internal audit system - 2013 schedule and associated records reviewed confirm audits have been done as planned. Records of regular meetings to monitor and review quality activities were sighted - weekly administration, health and safety monthly, staff monthly, RNs monthly, diversional therapy weekly. Recommendations for remedies, changes, improvements are identified by the NM following audits and incidents. NM signs them off when effectively implementedThe NM collates a monthly quality report that is posted in the staff room and the RN office. Monthly Risk Report includes data relating to clinical incidents (behaviour, falls, skin tears, pressure areas, infections), other incidents, enablers, quality achievements, staff and education. Infections are benchmarked with other aged care facilities through an external agency. The NM participates in the ADHB Steering Group and cluster groups with nurse specialists on falls and pressure injuries.Risk management plan and register of potential and actual risks is maintained and reviewed at least bi-annually, in May and Nov. Sighted Risk Register, last reviewed Nov.2013. Health and safety plan reviewed annually in March with input from all staff. Sighted health and safety audits. Actions required to correct deficits and improve services are identified in the event reports and reviewed at quality team meetings. Relevant ARC requirements are met. |

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(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.

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

##### **Criterion 1.2.3.4 (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):**  *(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.

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

##### **Criterion 1.2.3.6 (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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

##### **Criterion 1.2.3.9 (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):**  *(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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A documented policy identifies situations that require specific notification to particular persons or agencies, including Public Health Officer and the Ministry of Health. None have been required in the last 12 months. An incident register and associated documents are maintained. Adverse, unplanned and untoward events are recorded by staff on an incident form and reviewed by the NM. Recommendations for remedy, correction and prevention are documented by the NM and signed off by her when they are verified as effectively implemented. Review of six incident records indicates that improvement is required to ensure that neurological assessment is consistently done following a resident fall. Relevant ARC contract requirements are met. |

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

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

|  |
| --- |
| **Attainment and Risk:** 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 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Review of seven adverse event records in resident files relating to resident falls, both witnessed and unwitnessed, found that six of the seven had no evidence of a post fall neurological assessment.  |
| **Finding:** |
| Neurological assessments are not consistently done following a resident fall. |
| **Corrective Action:** |
| Consistently conduct and document neurological assessments following a resident fall. |
| **Timeframe (days):** 60 *(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:** |
| Processes are implemented to ensure that professional qualifications are checked prior to employment or engagement, including those of the visiting doctors, physiotherapist and podiatrist. The Nurse Manager maintains a list of all staff who require current practising certificates. Review of the list and a check sample of three staff files indicate that practising certificates are up to date. Sound appointment processes are clearly documented in an Employment Policy. Written applications, CVs and references are required. Personnel records provide evidence of consistent pre-employment interview and referee checking. Review of position descriptions for registered nurse and care giver against the experience and qualifications of the incumbent staff member indicate appropriate appointments are made.A documented orientation programme is in place. Elements include the facility philosophy and culture, health and safety, infection control, Code of Rights, the call bell system, emergency protocols, location of policy manuals, use of phones, complaints process, manual handling, use of personal protective equipment. There is a buddy process for introducing a new staff member to the practicalities of the role for which they have been employed. An evaluation of practical competence is done at three months. Orientation records in five of five randomly selected staff records confirm implementation.There is a planned programme of ongoing staff education. Topics meet ARC contract requirements and are appropriate to the levels of care provided. Review of both session and individual records and staff interviews indicate the programme is implemented as planned. Annual performance appraisals are conducted for all staff. Relevant ARC contract requirements are met |

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

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

|  |
| --- |
| **Attainment and Risk:** 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:** |
| The resident rooms are situated on three floors serviced by two stair wells and an elevator. A documented staffing policy sets out appropriate staffing levels and skill mixes for the three floors. Staff interviews and staff rosters indicate it is implemented in practice.  At least one RN is on duty 24 hours a day. There are two care givers in the morning and the afternoon, and one at night. Staff interviewed say that this is sufficient. Nurse Manager and senior RN are on duty office hours Monday to Friday. An appointed general practitioner visits the facility at least weekly and as required. Associated health professionals include a full time activities coordinator, a visiting physiotherapist and a podiatrist available by appointment. There are on average 3.98 care hours per resident per day. Resident surveys, staff interviews, complaints records and analysis of incident forms indicate that this is sufficient to provide safe, effective care over the 24 hour period. Staff say that additional help is brought in if workloads require it. The NM or a senior RN are on call after hours, Emergency calls from independent apartments in the same building as the care unit are attended by a staff member with a current first aid certificate. The RN can be contacted by mobile phone for advice but does not leave the care unit. If further care is required an ambulance is called and the resident is transferred to the local emergency care facility.Relevant ARC contract requirements are met |

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Each stage of service provision is completed by a suitably qualified person. Assessments and care plans are developed and reviewed by a registered nurse with a current practicing certificate. Daily interventions and support with activities of daily living are implemented with the help of trained care givers and allied health providers. For example the general practitioner (GP), physiotherapist, diversional therapist and podiatrist. Timeframes for service delivery are defined and met as evident in the five residents' files sampled. The sample includes three residents receiving rest home level care and two residents receiving hospital level care. An initial nursing assessment/short term plan is performed on admission by the registered nurse and a medical assessment conducted by the GP within forty eight hours. Following this the life style care plan is developed and implemented to meet the identified needs and goals of the resident. Short term care plans are also developed in the event of short term needs. For example a wound or an infection.A care review meeting is completed every six months. This process is conducted by the nurse manager and includes the resident and family. The required reviews are sighted in files sampled and have been conducted within the defined timeframe.Continuity of care is maintained. Residents' files sampled evidence multidisciplinary involvement and daily handovers ensure day to day continuity. A handover is observed and confirms relevant and appropriate information sharing about resident’s needs.The District Health Board contract requirements have been met. For example, residents are assessed by their GP on entry, responsibilities for the provision of daily care is identified during the handover reports and lifestyle care plans are comprehensive and include the required domains.Hospital resident file reviewed using tracer methodology: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*Rest home resident file reviewed using tracer methodology: XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** 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 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The life style care plan includes concerns/problems, nursing goals and resident goals. Interventions are then documented and address each domain/goal or identified problem. Interventions sighted are commensurate with assessed needs and goals and are consistant with best practice in working with older adults. The GP interviewed is satisfied that clinical interventions are implemented in a timely and competent manner, with a good dose of ‘common sense’. Interventions from allied health providers are also given due consideration. For example a physiotherapy functional assessments (and required interventions) are sighted in resident files sampled.The previous opportunity regarding the use of short term care plans has been adequately addressed in the fives files sampled. Several short term care plans are sighted (refer # 1.3.3).Continence and pain assessments also include a management plan. The physiotherapist also develops a transfer plan for all residents which includes the required interventions/actions to maintain safe transfers and mobility.Two additional files are sampled in order to confirm the appropriate management/interventions in the event of a restraint or wound. Wound care plans include the required assessment and monitoring interventions and the need for bed rails is adeqautely assessed and monitoring/safety interventions documented.The Distrist Health Board contract requirements have been met. |

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

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

|  |
| --- |
| **Attainment and Risk:** 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 1.3.7: 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:** |
| The activity programme is developed and coordinated by an activities coordinator. The activities coordinator is on site three days per week; however the coordinator is not available on the day of the audit. Care giving staff interviewed are able to confirm their involvement in supporting the programme in the absence of the coordinator. The current activities plan is sighted and provides a sufficient range of planned activities to develop and maintain strengths and interests. Regular exercises and outings are provided for those able to partake. Past activity plans sighted also confirm that a wide range of group activities have been consistently provided. In addition, each resident has a social history/activities assessment completed on entry. From this an individual activities care plan and goals are developed. Participation in activities is monitored and the review process includes an evaluation towards activity goals. All residents’ files sampled have the required activities assessment.The monthly Diversional Activities Reports for 2013 are sighted. These report on the aims and achievements of the programme and confirm a fully functional programme is in place. Two residents interviewed are satisfied with the activities provided and confirm participation is voluntary. The April 2013 resident satisfaction survey and analysis confirms that 41% of those surveyed felt the recreation programme was very good and 55% felt it was good.  The District Health Board contract requirement are met. |

##### **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:** |
| The care review process ensures a comprehensive review of care is conducted every six months. The review is conducted by the nurse manager and includes input from the staff, the resident and family. Care reviews include a review of recent medical history, brief social background, current health status, presenting issues/concerns and care needs, outcome and any follow up actions required. Care reviews are sighted in resident files sampled and life style care plans updated when required. In addition, life style care plans are reviewed by the registered nurse every three months to ensure currency, and daily checklists are completed by the care givers which indicate achievement in maintaining activities of daily living. Wound and infection care plans are evaluated as and when required. Three monthly GP reviews are also evident in resident files sampled. The District Health Board contract requirements are met |

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There are adequately documented policies and procedures for all stages of medicine management. Policies reflect legislative requirements and safe practice guidelines. The pre-packed medication packs (Robotic System) is implemented. All medicines are prescribed by the one GP. Prescriptions are legible, signed and dated appropriately.Three monthly medication reviews are evident. The previous opportunity for improvement regarding prescribing has been adequately addressed.Medications are stored securely and safely in the nurses’ station. There is limited stocked medication kept on site and these mainly consist of antibiotics. The medicatioin cupboard is checked and confirms all non-packaged medication is within the expiry date. The medication fridge is maintained at a stable temperature. The process of obtaining a telephone order from the GP is sampled and completed as per policy requirements. There is a standing order for the use of oxygen, however this has not been documented in a manner consistent with the 2012 Standing Orders Guidelines resulting in a low risk opportunity for improvement.There are two hospital residents who are prescribed controlled drugs on the regular basis. Controlled drugs are safely stored. Two controlled drug registers are maintained. One for hospital residents and one for rest home residents. The controlled drug registers are sampled and evidence the correct balance. The required pharmacy checks of controlled drugs are also being conducted six monthly. Medications are administered by the registered nurses in the hospital and senior caregivers in the rest home. Competencies for medication management are assessed by the nurse manager. The registered nurses complete a clinical assessment medication management questionnaire and the caregivers a competency questionnaire annually. A lunch time medication round is observed. It is noted that best practice was not consistently maintained resulting in a moderate risk opportunity for improvement.Medication files are sampled (10). All medication files meet requirements. Allergies are recorded, photo identification is in place and administration records maintainedThere is currently one resident who is self-administering eye drops and lactulose. Competency to do so has been assessed by the GP and documented in the resident’s file.Medication errors are reported using the adverse event process. Medication incidents are sampled and include a combination of dispensing errors, medications dropped or spilt and/or given at the wrong time of the day. In each event, an appropriate response (and follow up actions) have been implemented, however there is no process for reviewing the competency path of nurses following a medication error.The District Health Board contract requirements are met. Policies comply with the Medicines Act 1981 and residents medication is reviewed on entry to the facility. This includes a medication reconciliation (sighted in GP records). |

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Previous opportunities for improvement regarding the prescribing and administration of medication has been adequately addressed. An additional opportunity for improvement is written with regard to standing orders. |
| **Finding:** |
| The medication policy makes reference standing orders for the use of oxygen; however this is yet to be documented in manner which complies with the 2012 Standing Orders guidelines. |
| **Corrective Action:** |
| Fully document the standing order for the use of oxygen in line with the 2012 Standing Orders Guidelines. |
| **Timeframe (days):** 180 *(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:** PA Moderate |
| **Evidence:** |
| Although all staff are required to complete medication competencies, the auditor observed a registered nurse recapping a needle and not consistently signing the administration chart post administration. Two previous medication errors sighted occurred as a result of the nurse not checking the chart prior to administration. There is no process for reviewing the competency path of nurses following a medication error. |
| **Finding:** |
| Medication administration observed during the audit did not meet best practice and there is no process for reviewing the competency path of nurses following a medication error. |
| **Corrective Action:** |
| Review competencies for registered nurses administering medication. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.5 (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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The nutritional needs of residents are met. The residents nutritional status is assessed on admission and needs identified. Nutritional intake care plans are sighted in resident files sampled and consist of any concerns/problems, goals, interventions, allergies, normal/soft/pureed/dislikes/favourite foods and beverages. Level of assistance required is recorded. All residents are weighed monthly and the previous opportunity for improvement regarding weight monitoring has been addressed. In the event of unexplained weight loss a weight loss chart is developed indicating percent of loss and required interventions. A weight loss chart is sighted in the file sample. All food services are contracted to an external provider.The Chef is interviewed. The menu is based on a five week cycle. The menu plans are conducive for residents in an aged care residential setting and have been reviewed/audited by a dietician in 2012 to ensure appropriateness. This review is completed every two years. The kitchen is maintained in line with the external provider’s contract requirements. This includes complying with food hygiene standards and employing competent staff. Internal audits are reguallrly conducted to ensure compliance requirements are met. These include stock control and temperature monitoring. Satisfication surveys sighted confirm general satisfaction with the food. The chef is aware of likes and dislikes and provides alternatives if required. Records of any deviation from the menu are maintained. Fluids and snacks are readily available.The District Health Board contract requirements are met. |

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

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

|  |
| --- |
| **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 1.3.13.2 (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):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

|  |
| --- |
| **Attainment and Risk:** 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 1.4: Safe and Appropriate Environment**

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

#### Standard 1.4.1: Management Of Waste And Hazardous Substances  **(**HDS(C)S.2008:1.4.1)

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| A previous improvement required in relation to staff training about management of waste and hazardous substances has been effectively addressed. Review of staff training records indicates that all staff have attended such training in the last twelve months. Observation during the audit indicates that staff handle waste safely and appropriately in accord with facility policies. |

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

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

|  |
| --- |
| **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 1.4.2: 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:** |
| Eastcliffe was purpose built in 2001. The entire building and fittings are of a high standard. The facility is divided into three floors, with support services (kitchen and laundry) situated in the basement. The care facility is situated in a dedicated wing of three floors, with higher needs residents on level one. Each floor is generous in space, with hand rails in the corridors and wide doorways. The lift is large enough to accommodate beds, wheelchairs etc. Bedrooms are adequate in size with an individual ensuites. Floors are level and non-slip in all areas. External balconies have balustrades, seating and shade. There are level paved pathways in the grounds for resident use.The facility is well maintained. There is a "Maintenance Form" system used for requesting ongoing maintenance. Records show that maintenance is completed promptly. The current Building Warrant of Fitness expires on 21-Nov-2014. Equipment Policy sighted includes an equipment register and maintenance schedule and suppliers. A schedule for 3 monthly checks was sighted and includes blood pressure equipment, scales, wheelchairs, shower chairs, beds, hot water, hoists, sanitizers and electric beds. Service reports sighted indicate that the checks are maintained as scheduled. Records of electrical checks indicate that a previous improvement required in relation to maintenance of annual electrical checks has been effectively addressed.Relevant ARC requirements are met. |

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

All buildings, plant, and equipment comply with legislation.

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(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.

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

##### **Criterion 1.4.2.6 (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.)* |

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| A previous improvement required in relation to checking and calibration of the temperatures of the laundry machines has been addressed. An email was sighted from an external agency confirming that sanitisation is effected by the chemicals used, not by temperatures, and is effective in cold water. |

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

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

|  |
| --- |
| **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 1.4.7: Essential, Emergency, And Security Systems  **(**HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Fire Service approval of evacuation scheme for 217 Kupe St, Orakei on 24-July-2006. No alterations or extensions have been done since then. Staff training records indicate that trial fire evacuations have been done twice in the last twelve months and all but one staff member who works one day a week have attended at least once. The previous improvement required in relation to annual fire training for staff has been effectively addressed. |

# 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:** |
| Restraint minimisation is promoted by management and alternatives provided where able. For example low beds and sensor mats. The restraint minimisation and safe practice policy includes definitions for enablers and restraint. Staff training on the use of restraints/enablers and alternatives is provided. Nursing staff interviewed report the facility currently has one resident who has a bed rail in place and this is being correctly managed.Two previous opportunities for improvement regarding definitions of restraint and enablers (2.1.1.4) and restraint monitoring (2.2.3.4) have been adequately addressed. A restraint monitoring record/chart is sighted. Bed rails are monitored every two hours while in use. |

##### **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):**  *(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.

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| An appropriate surveillance programme is implemented and suitable to the services provided at the faciity. Standard defiinitions are used to identify infections for surveillance and best practice references are quoted. Infections data is collected and collated monthly in relation to both resident and staff infections and reported to the health and safety / infection control team meetings. The data is graphed to show incidence and trends over time. The nurse manager reports surveillance results to staff meetings. Review of data records for the last 12 months indicates that infection rates are low with no adverse trends identified.  |

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