Ki-Chi Service Supplies Company Limited

Current Status: 10 February 2014

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

General overview

Raglan Hospital and Rest Home is currently a 29-bed facility that provides rest home and hospital level care. On the day of the audit, there were 15 residents at rest home level care and 12 residents at hospital level care. A partial provisional audit has been undertaken to assess the service's readiness to provide hospital or rest home level care to a further seven residents in a newly built wing.

The facility manager/clinical director is a registered nurse who has managed the service for the past eight years. She is supported by the owner and a team leader who is a registered nurse with one year’s experience in aged care.

The audit identifies that the new wing and the services provided are suitable for rest home or hospital level care. The rooms are in a new wing and have ensuites and access to a disabled bathroom in the next wing. The lounge, dining and outdoor areas have been extended and appropriate extra equipment purchased to cater for a further seven residents.

Improvements required at the previous audit around registered staff practicing certificates, weighing residents on admission, completing care plans within three weeks of admission, registered nurse input into initial assessments, medication competency assessments, food storage, chemical storage and labelling, hoist servicing and surfaces in bathrooms and toilets have been addressed.

Improvements continue to be required around initial assessments, care plans and as required medication prescribing.

Further improvements are required to aspects of medication management, job description for the team leader, orientation for the team leader, food stored in the freezer, obtaining a certificate for public use and completing partially completed renovations to doors and windows in the existing home.

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:	Ki-Chi Service Supplies Company Limited
Certificate name:	Ki-Chi Service Supplies Company Limited

Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited

Types of audit:	Partial Provisional Audit
Premises audited:	Raglan Hospital and Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services – Sensory
Dates of audit:	**Start date:** 10 February 2014 **End date:** 10 February 2014

Proposed changes to current services (if any):
This audit has assessed seven new rooms at the service as able to cater for rest home or hospital level residents.

Total beds occupied across all premises included in the audit on the first day of the audit:	27

Audit Team

Lead Auditor	XXXXX	**Hours on site**	4	**Hours off site**	2.5
Other Auditors		**Total hours on site**		**Total hours off site**	
Technical Experts		**Total hours on site**		**Total hours off site**	
Consumer Auditors		**Total hours on site**		**Total hours off site**	
Peer Reviewer	XXXXX			**Hours**	1

Sample Totals

Total audit hours on site	4	Total audit hours off site	3.5	Total audit hours	7.5

Number of residents interviewed		Number of staff interviewed	3	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)	28	Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology				Number of GPs interviewed	

Declaration

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

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Thursday, 20 February 2014

Executive Summary of Audit

General Overview
Raglan Hospital and Rest Home is currently a 29-bed facility that provides rest home and hospital level care. On the day of the audit, there were 15 residents at rest home level care and 12 residents at hospital level care. A partial provisional audit has been undertaken to assess the service's readiness to provide hospital or rest home level care to a further seven residents in a newly built wing. The facility manager/clinical director is a registered nurse who has managed the service for the past eight years. She is supported by the owner and a team leader who is a registered nurse with one year's experience in aged care. The audit identifies that the new wing and the services provided are suitable for rest home or hospital level care. The rooms are in a new wing and have ensuites and access to a disabled bathroom in the next wing. The lounge, dining and outdoor areas have been extended and appropriate extra equipment purchased to cater for a further seven residents. Improvements required at the previous audit around registered staff practicing certificates, weighing residents on admission, completing care plans within three weeks of admission, registered nurse input into initial assessments, medication competency assessments, food storage, chemical storage and labelling, hoist servicing and surfaces in bathrooms and toilets have been addressed. Improvements continue to be required around initial assessments, care plans and as required medication prescribing. Further improvements are required to aspects of medication management, job description for the team leader, orientation for the team leader, food stored in the freezer, obtaining a certificate for public use and completing partially completed renovations to doors and windows in the existing home.

Outcome 1.1: Consumer Rights

Outcome 1.2: Organisational Management
Raglan Hospital and Rest Home has a current strategic and a current quality plan, which document current goals for the service including the changes to the building and external areas. The business plan and goals are formally reviewed annually and informally reviewed regularly between the manager and the owners. The manager is experienced and is supported by a team leader. In the absence of the manager, the team leader fills the management role, supported by the owner. There are improvements required around including management responsibilities in the team leader's job description and the team leader completing an appropriate orientation. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice around rest home level care and an in-service education programme that exceeded eight hours annually in 2013. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support for rest home and hospital level care with registered nurses on site 24 hours each day. A draft roster has been developed for when there are more hospital or rest home level residents that includes increased caregiver cover. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes appropriate for both hospital and rest home level care.

Outcome 1.3: Continuum of Service Delivery

A review of resident files show that all residents are weighed on admission and that when initial assessments are completed these are done by a registered nurse. There are improvements required around ensuring an initial assessment and care plan are completed and care planning.
The medication management system includes the medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: Safe Management of Medicines. Resident medication files reviewed indicate that all residents have a medication chart that includes a photo and has been reviewed three monthly by a doctor. Medication is administered from a medication trolley by enrolled nurses and registered nurses who have been assessed as competent. There are improvements required around dating eye drops when opened, correct prescribing of as required medications, administering medications as prescribed, disposing of expired medications and management of anticoagulation therapy.
There are food service policies in place and the kitchen staff have all attended food handling training. The kitchen contains appropriate cooking and storage equipment. There is a preparation area and receiving area. Diets are modified as required.
An improvement is required around sealing food stored in the freezer.

Outcome 1.4: Safe and Appropriate Environment

Chemicals are stored in a locked cupboard and appropriately labelled. Appropriate policies are available and education on hazardous substances occurs at orientation and is included in the in-service education schedule. There is personal protective equipment.
The building holds a current warrant of fitness. There is an improvement required to obtain a certificate of public use.
The seven rooms in the new wing were assessed in this audit to establish if they are able to be rest home or hospital rooms and all rooms are large enough to cater for hospital level residents and their associated carers and equipment. The lounges, dining room and external areas have been extended to cater for the extra residents.
All rooms have the ability to have a hospital bed in the room and for residents to be transferred between rooms in a hospital bed. The service has purchased appropriate equipment to allow them to commence providing rest home or hospital level care to an extra seven residents. Other equipment will be purchased on an as needs basis. There is an improvement required around completing renovations to some doors and windows in the existing building. There are two lounges and a large dining area. All are used for activities and there is ample room for fallout chairs. There are chairs in corridors that allow residents to rest when navigating hallways and hallways that allow equipment and residents to move easily and safely.
There are outdoor areas that are easily accessible for residents with ramps and paths and an internal courtyard.
Cleaning and laundry services are monitored throughout the internal auditing system and the laundry has a clean/dirty flow with soiled linen transported from the sluice room in covered bins. Staff receive training at orientation and through the in-service programme.
Appropriate training, information, and equipment for responding to emergencies is provided. Staff have completed six monthly fire drills and these are planned to continue. A fire evacuation plan has been approved by the New Zealand Fire Service to include the new wing. There is a staff member on each duty that has a current first aid certificate. The facility is secured during the hours of darkness.
The facility is light, warm and airy. Smoking is only allowed outside away from residents' rooms and communal areas.
Call bells are currently installed in all areas including the new wing.

Outcome 2: Restraint Minimisation and Safe Practice

Outcome 3: Infection Prevention and Control
Raglan Hospital and Rest Home has an implemented infection control programme. The infection control programme its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service and is linked into the quality system. Infection control is incorporated into the quality/staff meetings and minutes are available for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	11	0	4	3	0	0
Criteria	0	31	0	4	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	32
Criteria	0	0	0	0	0	0	0	63

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.2.2: Service Management	The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	PA Low			
HDS(C)S.2008	Criterion 1.2.2.1	During a temporary absence a suitably qualified and/or experienced person performs the manager's role.	PA Low	The team leader job description does not include undertaking management responsibilities in the absence of the	Ensure the team leader job description includes undertaking management responsibilities in the absence of the manager/clinical director.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				manager/clinical director.		
HDS(C)S.2008	Standard 1.2.7: Human Resource Management	Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low			
HDS(C)S.2008	Criterion 1.2.7.4	New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	The team leader (a registered nurse) who has been at the service for one year does not have a documented record of orientation.	Ensure all staff complete an orientation and that a record of this is kept.	Prior to occupancy
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.4.2	The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	Two of the five files sampled were for the only two residents admitted since the previous audit. One of these residents did not have an initial assessment or care plan developed.	Ensure that all residents have an initial assessment completed.	60
HDS(C)S.2008	Standard 1.3.5: Planning	Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.5.2	Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	One of the five resident files sampled did not address areas of need including weight loss, falls risk and constipation. Another of the five files for a recently admitted	Ensure all residents have a care plan that documents interventions to address all areas of identified need.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				resident did not have any care plan at all.		
HDS(C)S.2008	Standard 1.3.12: Medicine Management	Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	(i)Five of ten medication charts have PRN medications prescribed that do not document an indication for use. (II) Two of ten medication files sampled have two incidents in the past month where regular blistered medications have not been signed as administered. A further two medication charts had regular non-packaged medications that have not regularly been signed as administered. (iii) The one bottle of eye drops in use has not been dated when it was opened. (iv) There are expired medications in the medication cupboard. (v) One resident on warfarin has no current GP instruction relating to dose in the medication file.	(i)Ensure that all PRN medication prescriptions document the indication for use. (ii) Ensure medications are administered as prescribed. (iii) Ensure eye drops are dated when they are opened. (iv) Ensure expired medications are returned to the pharmacy. (v) Ensure that current GP instructions for warfarin doses are available for staff administering the warfarin.	30
HDS(C)S.2008	Standard 1.3.13: Nutrition, Safe Food, And Fluid	A consumer's individual food, fluids and nutritional needs are met where this service is a	PA Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
	Management	component of service delivery.				
HDS(C)S.2008	Criterion 1.3.13.5	All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	There are several unsealed items of food in the freezer.	Ensure all food in the freezer is sealed.	90
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Low	(i)A certificate for public use has not yet been issued. (ii) The window surrounds in 11 existing rooms and door surrounds on six existing rooms are exposed and unfinished while doors and windows are being replaced.	(i)Provide evidence of a certificate of public use. (ii) Continue the process of replacing and finishing the doors and windows.	Prior to occupancy

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Raglan Hospital and Rest Home is currently a 29-bed facility that provides rest home and hospital level care. On the day of the audit, there were 15 residents at rest home level care and 12 residents at hospital level care. A partial provisional audit has been undertaken to assess the service's readiness to provide hospital or rest home level care to a further seven residents in a newly built wing. There is a Cavell group strategic plan. The mission states, "The Cavell Group is an association of five individually owned residential aged care providers. The facility is independently owned since August 2011. The strategic plan includes objectives and strategies for their achievement.

Raglan Hospital and Rest Home is using the Cavell Group mission and quality policy and a Raglan Hospital and Rest Home quality plan Jan 2012 - Jan 2015 is documented. This includes goals around health and safety, infection control, food safety, quality systems, care planning, staff education, capital project programmes, equipment upgrades, marketing, building plans, outdoor projects and fundraising. The documented mission statement is that 'Raglan Hospital and Rest Home is a small residential care facility committed to excellence in care. We welcome the opportunity to meet the needs of each resident, be available to consult and be informative with their family, and conduct our business with honesty and integrity'.
The manager/clinical director reports weekly to the owner on a range of operational matters including strategic and operational issues, incidents and accidents, complaints, health and safety.
The quality and risk management system includes the collection of both quantitative and qualitative quality improvement data within the group of facilities and review of information as provided by the service. The owner also monitors risks associated with the business in partnership with the Cavell Group (incident and accident reporting, infection control, occupancy). The service used to be engaged in peer review and other benchmarking but since the change in ownership has become more self-sufficient.
Service appropriate management systems, policies, procedures, codes of practice and guidelines are implemented and maintained. This includes an internal audit system to regularly assess service performance with its systems and communication of results to staff.

The manager/clinical director for the past eight years is a registered general nurse with aged care management experience. She is supported by a team leader (registered nurse) and the owner who visits at least weekly.

ARC, D17.3di: The manager/clinical director has maintained at least eight hours annually of professional development activities related to managing an aged care facility. In 2013, this included a five hour New Zealand Aged Care Association managers training day and regular Cavell Group managers' meetings three times.

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 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

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

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

Attainment and Risk: PA Low
Evidence: Where the manager/clinical director is absent, the owner and the team leader provide oversight of the service. The team leader has been at the service for one year. The team leader job description does not include undertaking management responsibilities in the absence of the manager/clinical director and this is an area requiring improvement. In the event of the manager /clinical director taking a longer planned break, the previous clinical manager returns temporarily to manage the facility. A review of the documentation, policies and procedures and from discussion with staff identified that the quality and risk management programme includes minimisation of risk of unwanted events and enhance quality. The service has well-developed policies and procedures at a service level and organisation plan is structured to provide appropriate safe quality care to people who use the service including residents that require hospital, medical care and rest home care. D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.

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

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

Attainment and Risk: PA Low
Evidence: Where the manager/clinical director is absent, the owner and the team leader provide oversight of the service. The team leader has been at the service for one year. The team leader job description does not include undertaking management responsibilities in the absence of the manager/clinical director and this is an area requiring improvement. In the event of the manager /clinical director taking a longer planned break, the previous clinical manager returns temporarily to manage the facility.
Finding: The team leader job description does not include undertaking management responsibilities in the absence of the manager/clinical director.
Corrective Action: Ensure the team leader job description includes undertaking management responsibilities in the absence of the manager/clinical director.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: PA Low

Evidence:

The skills and knowledge, outcomes, accountability, responsibility, authority and functions are documented in job descriptions. There are job descriptions available for all relevant positions and staff has employment contracts (link 1.2.2 relating to job description for the team leader). Task lists are available for all shifts.
There is a comprehensive human resources manual with copies of each job description which include the main purpose of the position, who they report to and key results and performance measures. There was a relevant job description sighted on all five staff files sighted.
All registered nurses practicing certificates were sighted and are current for all seven registered nurses (including the manager/clinical director) and the enrolled nurse. This is an improvement since the previous audit.
A central file contained copies of practicing certificates for the physiotherapist, dietitian and all doctors involved with residents at the service.
There are comprehensive human resources policies. The staff employment procedure includes recruitment, selection, orientation and appraisal. The training policy includes orientation, core training requirements, competency and planned training.
Recruitment, selection and appointment of staff policies are in place.
Four of five staff files were viewed all contained orientation documentation, reference checks, police checks, signed job descriptions. This is an area requiring improvement.
Five of five staff files sampled had recently completed performance appraisals.
There is a file checklist at the front of each file.
The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. This is described in the staff employment procedure and training policy.

The service has a comprehensive internal training programme.
Discussion with the manager/clinical director and a review of training records confirmed that a comprehensive in-service programme is training in relevant aspects of care and support and in relation to the requirements.
Registered nurses attend external training as available through the DHB and the gerontology nurse specialist visits the service when needed. The annual training programme well exceeds eight hours annually. Six of the seven registered nurses (all six, excluding the manager/clinical director are new graduates) are enrolled to commence the DHB PDRP programme in March 2013. One registered nurse is already enrolled in and has commenced the PDRP programme.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including medication competencies.

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: PA Low
Evidence: The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. This is described in the staff employment procedure and training policy.
Finding: The team leader (a registered nurse) who has been at the service for one year does not have a documented record of orientation.
Corrective Action: Ensure all staff complete an orientation and that a record of this is kept.
Timeframe (days): Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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 governance policy states that staffing levels shall be adequate to meet the needs of client care. (NZS 8134 Section 2.7) and that there shall be a registered nurse on duty at all times at Te Puke, Raglan, and Acacia Park, or the Ministry of Health is to be notified every time there is no registered nurse available. The workload management policy states that workload monitoring is undertaken at all sites on a regular basis. There is a policy around acuity and staffing ratio. There is a documented rationale for staffing the service. Staffing rosters were sighted and staff on duty to match needs of different shifts. Manager/clinical director (RN) - Full time Monday to Friday There is a registered nurse at all times who works across the rest home and hospital areas. Enrolled nurse – three shifts per week on care duties and two days per week in administration. Caregivers: 0615 - 1445 - I caregiver 0645 – 1555 – 1 caregiver 0645 - 1315 – 1 caregiver 1430 – 2230 – 1 caregiver 1445 – 2315 – 1 caregiver 2215 – 0615 – 1 caregiver 2245 – 0715 – 1 caregiver Once at full capacity with the five new beds an additional caregiver will be employed from 0830 – 1230 and another from 1445 – 2045. These staff are complimented by kitchen staff, cleaning and laundry staff, an activities coordinator and a maintenance person (25 to 30 hours per week).

The service contracts with allied health professionals including a dietitian and a physiotherapist on an as required basis. The GP visits weekly plus as required. When the service increases the number of hospital residents the GP's contact has been increased to include twice-weekly visits on a Monday and Thursday plus as required. The GP covers after hours including weekends.

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): Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: FA
Evidence: The previous audit identified that residents were not being weighed on the day of admission. Two of the five files sampled were for residents who have been admitted since the previous audit. Both had been weighed on the day of admission. The previous shortfall has been addressed. The previous audit also identified that long-term care plans were not being developed, documented and evaluated by a registered nurse within three weeks of admission. There have only been two residents admitted since the previous audit. One did not have an initial care plan or assessment (link 1.3.4.2 and 1.3.5.2). The other resident had a long-term care plan developed by a registered nurse within three weeks of admission. This shortfall has also been addressed.

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

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

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 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

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

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

Attainment and Risk: PA Moderate
Evidence: The previous audit identified that initial care plans and assessments require evidence of registered nurse input and agreement in evaluating the initial care (D16.2 & D16.3c). Two of the five files sampled were for the only two residents admitted since the previous audit. One of these residents had an initial assessment and care plan developed by a registered nurse. The other resident did not have an initial assessment or care plan developed. This area continues to require improvement.

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

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

Attainment and Risk: PA Moderate
Evidence: The previous audit identified that initial care plans and assessments require evidence of registered nurse input and agreement in evaluating the initial care (D16.2 & D16.3c). Two of the five files sampled were for the only two residents admitted since the previous audit. One of these residents had an initial assessment and care plan developed by a registered nurse. The other resident did not have an initial assessment or care plan developed. This area continues to require improvement.
Finding: Two of the five files sampled were for the only two residents admitted since the previous audit. One of these residents did not have an initial assessment or care plan developed.

Corrective Action: Ensure that all residents have an initial assessment completed.
Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Attainment and Risk: PA Moderate
Evidence: The previous audit identified that service delivery plans do not describe the required support and interventions identified by the assessment process and plans do not guide care or contain links to other documentation included elsewhere in the clinical record. Additional instructions were not recorded on a short-term care plan. Five resident files were sampled for this audit. Three had long-term care plans that included interventions related to all areas of need identified in the assessment process. One of the five resident files sampled did not address areas of need including weight loss, falls risk and constipation. Another of the five files for a recently admitted resident did not have any care plan at all. Care planning continues to require improvement. Two of the five files had short term care plans to address areas of need. The other three files sampled had not had any acute or short-term needs.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: PA Moderate
Evidence: The previous audit identified that service delivery plans do not describe the required support and interventions identified by the assessment process and plans do not guide care or contain links to other documentation included elsewhere in the clinical record. Additional instructions were not recorded on a short-term care plan. Five resident files were sampled for this audit. Three had long-term care plans that included interventions related to all areas of need identified in the assessment process. One of the five resident files sampled did not address areas of need including weight loss, falls risk and constipation. Another of the five files for a recently admitted resident did not have any care plan at all. Care planning continues to require improvement. Two of the five files had short term care plans to address areas of need. The other three files sampled had not had any acute or short-term needs.
Finding: One of the five resident files sampled did not address areas of need including weight loss, falls risk and constipation. Another of the five files for a recently admitted resident did not have any care plan at all.
Corrective Action: Ensure all residents have a care plan that documents interventions to address all areas of identified need.
Timeframe (days): 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Attainment and Risk: PA Moderate

Evidence:

Ten resident medication files were reviewed and all medication looked at in the locked cupboard. The facility uses the medication management system Medico packs that are delivered in four-week supply. Staff check the delivery and there is a verification sheet that details any discrepancies. There are expired medications in the medication cupboard and this is an area requiring improvement. A current pharmacy agreement was sighted. The only bottle of eye drops in use at the time of the audit had not been dated when opened. This is also an area requiring improvement.
The organisations medication policies and procedures cover medication prescribing, dispensing, administration, review, storage, disposal and medication reconciliation, and follow recognised standards and guidelines for safe medicine management practice. Medications are prescribed by the residents GP, on a medication prescribing sheet. The indication for PRN medicine orders is not always documented by the prescriber. This shortfall was identified in the previous audit and continues to require improvement. Controlled drugs are stored in a locked safe in a locked cupboard. There is one controlled drug register and this was noted to be current and signed by two people with weekly stocktakes having occurred.

Staff are assessed as competent to undertake medication administration through the annual competency assessment. There is evidence of on-going education and training of staff in relation to medicine management. Registered nurses or the enrolled nurse who have completed and passed a medication competency administer medication. This is an improvement since the previous audit. All staff that administer medication are competent and have received medication management training in 2013. The enrolled nurse interviewed was conversant with the service medicine management policies procedures. However, two of ten medication files sampled have two incidents in the past month where regular blistered medications have not been signed as administered. A further two medication charts had regular non-packaged medications that have not regularly been signed as administered. In addition, one resident on warfarin has no current GP instruction relating to dose in the medication file. These are further areas requiring improvement.

Raglan Hospital and Rest Home has medication management policies and procedures that ensure: a) residents medicine allergies/sensitivities are known and recorded, b) adverse reactions and administration errors are identified and appropriate clinical intervention occurs and c) adverse reactions and administration errors are recorded. Medication errors are treated as an incident and reported on the incident/accident form that all adverse reactions and errors are reported on. Medication error analysis occurs monthly as part of the incident reporting system. Allergies are recorded on the residents' admission records; medication profiles and drug administration records. There is a self-medication agreement that is signed by each resident who is self-medicating. There is a self-medicating resident's policy available to guide staff practice if required The registered nurse completes and education and assessment of the resident's suitability to self-medicate safely. There are currently two residents at Raglan Hospital and Rest Home self-administering medicines and both have a current competency assessment.
D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

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

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

Attainment and Risk: PA Moderate

Evidence:

Ten resident medication files were reviewed and all medication looked at in the locked cupboard. The facility uses the medication management system Medico packs that are delivered in four week supply. Staff check the delivery and there is a verification sheet that details any discrepancies. A current pharmacy agreement was sighted.

The organisations medication policies and procedures cover medication prescribing, dispensing, administration, review, storage, disposal and medication reconciliation, and follow recognised standards and guidelines for safe medicine management practice. Medications are prescribed by the residents GP, on a medication prescribing sheet. Controlled drugs are stored in a locked safe in a locked cupboard. There is one controlled drug register and this was noted to be current and signed by two people with weekly stocktakes having occurred. Staff are assessed as competent to undertake medication administration through the annual competency assessment. There is evidence of on-going education and training of staff in relation to medicine management. Registered nurses or the enrolled nurse who have completed and passed a medication competency administer medication. This is an improvement since the previous audit. All staff that administer medication are competent and have received medication management training in 2013. The enrolled nurse interviewed was conversant with the service medicine management policies procedures.
Finding: (i)Five of ten medication charts have PRN medications prescribed that do not document an indication for use. (II) Two of ten medication files sampled have two incidents in the past month where regular blistered medications have not been signed as administered. A further two medication charts had regular non-packaged medications that have not regularly been signed as administered. (iii) The one bottle of eye drops in use has not been dated when it was opened. (iv) There are expired medications in the medication cupboard. (v) One resident on warfarin has no current GP instruction relating to dose in the medication file.
Corrective Action: (i)Ensure that all PRN medication prescriptions document the indication for use. (ii) Ensure medications are administered as prescribed. (iii) Ensure eye drops are dated when they are opened. (iv) Ensure expired medications are returned to the pharmacy. (v) Ensure that current GP instructions for warfarin doses are available for staff administering the warfarin.
Timeframe (days): 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

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

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

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

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)
A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

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

Attainment and Risk: PA Low
Evidence: There is a nutrition management and food control plan. The plan includes a food safety and nutrition policy that states "We will serve attractive and tasty food, which meets the preferences and nutritional requirements of our clients and is safe to eat. Our food suppliers are committed to supplying quality products that are transported at their correct storage temperatures. We work as a team to produce food that meets the standards in our nutritional and safe food management programme. Compliance

with our programme is monitored and audited regularly". The plan includes a section on menu planning that states "A rotational menu is planned and adhered to; taking into account seasonal variations and individual residents' likes and dislikes, community norms, social and cultural needs. Menus are reviewed. A registered dietician will have input into the menu. Menus will comply with MOH food and nutrition guidelines wherever practicable or appropriate".

There is head cook and two other cooks who work in the kitchen. D19.2 All three cooks have been trained in safe food handling.
There is a nutritional profile on all residents that is completed on admission. Individual resident preferences are written on an information page in the kitchen. There is an external provider dietician available for individual resident need and for menu development. The six weekly menu is varied with evidence of review. The menu was last reviewed by a dietitian on 13 January 2014. Resident's surveys describe satisfaction with the food. Meals supplied include as routine, breakfast, lunch, dinner, morning tea, afternoon tea and supper. These meals are served at times that reflect community norms. Outside of regular meal times, staff will provide a nutritious snack or drink if residents are hungry or thirsty. Residents' weight is recorded on admission and monthly thereafter and were stable in all residents' records sighted.
The nutrition management and food control plan includes a section on special or modified diets. It states "as part of the care planning process, residents may be assessed as needing: special diets; fluid monitoring; weight monitoring; and special equipment such as feeding cups and non-slip mats. These requirements will be arranged by the home as necessary". Raglan Hospital and Rest Home has special equipment available if required such as feeding cups and built up cutlery, lipped plates, non-slip mats available for residents that require these items listed are per care plan documentation.

All residents have a nutritional profile on admission, which identifies likes dislikes allergies and cultural requirements. Specific foods are available such as diabetic or modified foods, developed with dietician input if required. The cook interviewed reports that she is able to cater for dietary requirements and provides a diabetic diet. A diet with no pork or beef for religious reasons and one high calorie diet. One resident on a PEG feed has evidence of dietitian input.
Residents' dietary profiles indicate likes and dislikes and allergies. Profiles are conducted on admission. Residents are assessed on admission for food likes, dislikes and allergies and this is communicated to the cook. Preferences are met when possible.

There is a comprehensive cleaning schedule. The main grocery shop occurs weekly according to the menu. Food is stored in the pantry, the fridge and the freezer. Food sighted in the fridge, freezer and pantry was dated and raw food was stored below cooked food. New dry food storage containers have been purchased since the previous audit and this is an improvement. There are several unsealed items of food in the freezer and this is an area requiring improvement. Different coloured chopping boards are used for different food types and there is a roster for kitchen cleaning. All chemicals sighted in the kitchen are labelled and this is a further improvement since the previous audit. The kitchen was clean on the day of the audit. The fridge and freezer temperatures are recorded weekly and records sighted show that these are within safe limits. Food temperatures are also measured and recorded before food is served. The kitchen is well able to cater for the extra seven residents.

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: PA Low
Evidence: There is a comprehensive cleaning schedule. The main grocery shop occurs weekly according to the menu. Food is stored in the pantry, the fridge and the freezer. Food sighted in the fridge, freezer and pantry was covered and dated and raw food was stored below cooked food. New dry food storage containers have been purchased since the previous audit and this is an improvement. Different coloured chopping boards are used for different food types and there is a roster for kitchen cleaning. The kitchen was clean on the day of the audit. The fridge and freezer temperatures are recorded weekly and records sighted show that these are within safe limits. Food temperatures are also measured and recorded before food is served. The kitchen is well able to cater for the extra seven residents.
Finding: There are several unsealed items of food in the freezer.
Corrective Action: Ensure all food in the freezer is sealed.
Timeframe (days): 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: There is an infection control programme and policies documented. This includes (but is not limited to) the following policies: waste disposal; needles and sharps; disposal of sputum; blood related accidents; cleaning, disinfection and sterilisation; and specimen collection and transport. There is an incident reporting system that includes investigation incidents. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. The incident/accident reporting policy (part of the health and safety policy) requires that all incidents are reported. There is a hazard register. There is an incident reporting system that ensures all incidents involving infectious material, body substances or hazardous substances are reported recorded investigated and reviewed by the manger. These are discussed at the staff meetings and any changes or improvements to procedures implemented There is an emergency and civil defence plan. It includes a procedure on hazardous substance spills. The incident/accident reporting policy (part of the health and safety policy) requires that all incidents/accidents are reported. The incident reporting system ensures investigation of any incidents. Staff have been provided with training in chemical and waste management on orientation (documentation sighted). All staff on orientation to the facility receive infection control (covering waste and hazardous substances) education, including exposure to blood and body fluids. Training in the management of waste and hazardous substances last occurred in November 2013. All chemicals are appropriately labelled by the external chemical provider. The service has MSD sheets available where chemicals are stored. Sharps containers are appropriately labelled. There are two sluice rooms in the existing building that are suitable located and well able to cater for the new seven bed wing.

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.)*

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

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

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: PA Low
Evidence: The seven new hospital rooms are in a bright new wing. All are large enough to cater to the needs of rest home or hospital level residents and their required equipment including hoists and fall out chairs and at least two carers. Six of the new rooms have a shared ensuite with a toilet and shower and one room has a single ensuite. The lounge near the new wing has been extended and is well able to cater for a further seven residents. The dining room has also been extended and can cater for the extra seven residents. Two large decks have been built and both have views, seating and shade. The existing internal courtyard has been raised to level with the building and is now a fire egress. The wide hall in the new wing is fitted with handrails and all toilets have retractable rails. Flooring is carpeting in rooms, lounges and halls and non-slip vinyl in showers and toilets. Every room has an electric hospital bed and there are four existing hoists. An extra shower chair and four falls out chairs have been purchased. All new mattresses are pressure relieving mattresses. There are currently eight alternating air flow mattresses, three of which are in storage and could be used immediately for new hospital level residents requiring these. The manager/clinical director reports new equipment will be purchased on an as needs basis. Reactive and preventative maintenance is documented and implemented. The service has changed fire safety providers and the new provider has not yet checked the firefighting equipment. This was last tagged in January 2013. There is a current Building Warrant of Fitness that expires on 27 April 2014. A

certificate of public use has not yet been issued and this is an area requiring improvement. Electrical equipment is checked and tagged two yearly by an electrician and this last occurred in February 2014. Equipment is calibrated annually (documentation kept on premises). The hoists were serviced in January 2014 and this is an improvement since the previous audit. When an issue requiring maintenance is noticed the manager contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. Hot water temperatures are monitored weekly and records show they are within safe limits.
The maintenance person routinely works five hours per day, five days per week and is also available on an on call basis. External contractors are engaged to complete work as required.
Furniture and fittings in the facility have been selected with consideration to residents' abilities and functioning. Residents rooms allow care to be provided and for the safe use and manoeuvring of mobility aids. There are call bells throughout the facility and are easily accessible including in the new rooms and ensuites.
The resident information pack states that residents are encouraged to bring personal belongings or furnishings for their rooms. Residents' bedrooms have their own personal belongings displayed and some resident had their own furnishings.
As part of the renovation programme fire doors have been replaced in many rooms and all older sash style windows are currently being replaced with new windows and frames. The window surrounds in 11 existing rooms and door surrounds on six existing rooms are exposed and unfinished while doors and windows are being replaced. This is an area requiring improvement.
The grounds have ample space for residents to mobilise safely. There is an outside are now three decks with shade and seating. The preventative maintenance plan includes annual water blasting of decks.
There is a transport policy. A van is available for use to transport residents. All staff who drive have a current drivers licence and this is recorded annually. Consent to outings is in the resident's agreement. Where possible family are encouraged to accompany residents to appointments in the community and medical appointments and where this is not possible the service will endeavour to provide a staff member to accompany the resident as appropriate. The costs of transport that are met by the service and those that are not are clearly outlined in the resident admission agreement.
All chemicals sighted are locked either away or on the cleaner's trolley under direct supervision of the cleaner. All are appropriately labelled. This is an improvement since the previous audit.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Low

Evidence:

The seven new hospital rooms are in a bright new wing. All are large enough to cater to the needs of rest home or hospital level residents and their required equipment including hoists and fall out chairs and at least two carers. Six of the new rooms have a shared ensuite with a toilet and shower and one room has a single ensuite. The lounge near the new wing has been extended and is well able to cater for a further seven residents. The dining room has also been extended and can cater for the extra seven residents. Two large decks have been built and both have views, seating and shade. The existing internal courtyard has been raised to level with the building and is now a fire egress. The wide hall in the new wing is fitted with handrails and all toilets have retractable rails. Flooring is carpeting in rooms, lounges and halls and non-slip vinyl in showers and toilets. Every room has an electric hospital bed and there are four existing hoists. An extra shower chair and four falls out chairs have been purchased. All new mattresses are pressure relieving mattresses. There are currently eight alternating air flow mattresses, three of which are in storage and could be used immediately for new hospital level residents requiring these. The manager/clinical director reports new equipment will be purchased on an as needs basis.
Reactive and preventative maintenance is documented and implemented. The service has changed fire safety providers and the new provider has not yet

checked the firefighting equipment. This was last tagged in January 2013. There is a current Building Warrant of Fitness that expires on 27 April 2014. A certificate of public use has not yet been issued. This is an area requiring improvement. Electrical equipment is checked and tagged two yearly by an electrician and this last occurred in February 2014. Equipment is calibrated annually (documentation kept on premises). When an issue requiring maintenance is noticed the manager contacts the maintenance person on the same day and in most cases the issue can be repaired or resolved on the same day. Hot water temperatures are monitored weekly and records show they are within safe limits.
The maintenance person routinely works three hours per day, five days per week and is also available on an on call basis. External contractors are engaged to complete work as required.
As part of the renovation programme fire doors have been replaced in many rooms and all older sash style windows are currently being replaced with new windows and frames.

Finding:

(i)A certificate for public use has not yet been issued. (ii) The window surrounds in 11 existing rooms and door surrounds on six existing rooms are exposed and unfinished while doors and windows are being replaced.

Corrective Action:

(i)Provide evidence of a certificate of public use. (ii) Continue the process of replacing and finishing the doors and windows.

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

Criterion 1.4.2.4 (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 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)
Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: There are adequate communal toilets that are easily accessible and signed. Hand washing and drying facilities are available in each room and communal toilet. There is evidence of alcohol hand gel throughout the facility. There are adequate visitor's toilets with hand basins with paper towels ensuring infection control and prevention. All toilets are easily identifiable, with disabled access and have locks to ensure privacy. Six rooms in the new wing have a shared ensuite with a toilet and shower between each two rooms. The seventh room has a single ensuite with a shower and toilet. While these ensuites are not large enough to cater for a resident needing a hoist the manager/clinical director reports that caregivers would use the hoist to transfer the resident to a shower chair in the adjoining bedroom. One new shower chair has been purchased in addition to the six existing shower chairs. The disabled size bathrooms in the adjoining wing could be used if a resident needed this. The previous audit identified that there were broken surfaces in toilets and showers. All existing toilets and showers have been renovated and this issue has been addressed.

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

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

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

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

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

Attainment and Risk: FA
Evidence: There is adequate room in the seven new residents' bedrooms for personal belongings and room for both staff and residents. All rooms have enough space to allow the safe mobility of these residents, at least two staff and their equipment. The seven new residents' rooms all have doors that are double the width of ordinary doors and allow for the movement of residents in beds in the unlikely event that this were necessary.

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

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

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

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

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA
Evidence: There is good access for residents to both lounges and the dining area that meet the needs of the residents. Staff assist residents to access communal living areas as required and observed on the day of the audit. The lounge adjoining the new wing has been renovated and extended to almost double the size and is well able to cater for an extra five residents. The other main lounge has also been extended and now flows on to a large deck area. The dining has likewise been extended and is able to cater for an extra seven residents. There is room for residents to move freely with or without aids and independently or with assistance. Assistance from staff is provided where required - observed on the day of the audit. There are adequate areas provided for residents to ensure privacy and choice for relaxation and leisure. Residents can use their bedrooms and the outdoor areas, if they require privacy at any time.

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

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

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: There is a cleaning schedule and laundry management guidelines. There are also task lists for cleaning and laundry staff. New staff receive orientation in cleaning and laundry processes. Cleaning and laundry service is conducted by staff dedicated to these tasks. The service monitors the effectiveness of its laundry materials with the assistance of its chemical supplier. Laundry and cleaning internal audits are completed annually. An internal audit of the cleaning service was last conducted in January 2014 (100 % compliance) and of the laundry service was last completed in February 2014 (100% compliance). There are designated areas for storage of cleaning/laundry chemicals throughout the facility and laundry and cleaning storage areas. All chemical containers are clearly labelled and marked toxic.

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.)*

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

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

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: There is a comprehensive emergency and civil defence plan in place. Raglan Hospital and Rest Home has implemented policies and procedures for civil defence and essential, emergency and security systems. Staff are trained in fire safety and evacuation as part of orientation and at the six monthly fire evacuation drills last on 23 January 2014. Call bells are in use. Security procedures are established. The facility has 24 hour registered nurse on duty cover for medical emergencies and there are also staff on duty each shift with a current first aid certificate (renewed every two years). The new fire evacuation scheme to include the new parts of the building has been approved by the NZ Fire Service. The service has alternative cooking by way of a BBQ and extra blankets available in the event of a power failure. Battery operated emergency lighting is in place. The pantry holds supplies of food and there is stored water in a tank that exceeds 5000 litres that would more than support the residents for three days at three litres per day for each resident. Residents' rooms, communal bathrooms and living areas all have call bells. The seven new rooms have functioning call bells in the bedroom and one in the ensuite near the shower and another near the toilet. The renovated lounges both have call bells. Security policies and procedures are documented and implemented by staff. Afternoon and night staff ensure all outside doors and windows are securely locked. There is security lighting for after dark.

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Attainment and Risk: FA
Evidence:

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

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

Where required by legislation there is an approved evacuation plan.

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

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

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

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)
An appropriate 'call system' is available to summon assistance when required.

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)
The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)
Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA
Evidence:
The facility temperature is maintained with electric panel heating and opening windows and fans. All resident areas have external windows. The facility was a comfortable temperature on the day of the audit. The new wing has panel heating, double glazed windows and polystyrene insulation.

There is a smoking policy. The facility is smoke free internally and have external smoking areas available.

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

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

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 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

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

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

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

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is an infection control policy and procedure manual which is readily accessible to all staff. There is an established and implemented infection control programme. The manager/clinical director (who is a registered nurse) is responsible for infection control and prevention and collection of surveillance data. Infection control is a standing agenda item at the monthly staff meetings where all issues and infections are discussed and feedback to staff. All results and infection control matters are reported to the Cavell Group and the owner on a monthly basis. The infection control coordinator collates the monthly record of infections data every month and provides a report to the Cavell Group, the owner and the staff. Any emergent issues are informed promptly. The infection control coordinator and resident GP are promptly notified of any positive pathology that is identified as an infection. Any notifiable disease or serious outbreaks are notified to the appropriate authorities. There have been no outbreaks since the previous audit. There is a registered nurse available 24/7 on call for emergent issues. The infection control programme is documented as part of the infection control manual and is reviewed by the infection control team at Cavell Group annually. The infection control programme includes surveillance collection of data, analysis, education, audits of staff practise such as hand washing and infection control practices related to cleaning and laundry. The most recent annual review occurred in April 2013 .Staff are well informed about infection control practises and reporting. There is an infection control programme identified in the infection control manual/policies and procedures. This is integrated into the risk management system by the analysis of infection risks in the facility by monitoring, reporting and analysis of infection surveillance data, education and training effectiveness and cleaning and decontamination, housekeeping, waste disposal and laundry operation audits. The service gathers infection control data and analyses this to determine infection trends and risks. The infection control coordinator reports monthly to the Cavell Group and the owner. The report identifies any trends and potential infection risks these are discussed and strategies implemented to minimise and prevent infection. Any trends are reported to staff at the monthly staff meeting. There is an infection outbreak management policy, isolation policy and notification for infection. The role of infection control is clearly identified in the facility with the infection control role description and responsibilities included in the manager's portfolio. Infection control is discussed monthly staff meetings.

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

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

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 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

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