

Seniorcare Geraldine Incorporated

Current Status: 22 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

Seniorcare Geraldine Incorporated are the proprietors of Waihi Lodge care centre – situated in Geraldine, South Canterbury. The facility is managed by an enrolled nurse who reports to the chairman of the governing board. The service is certified to provide rest home level care and has a capacity of 19 residents. The service continues to implement a system of continuous quality improvement and residents and family spoken to advised that the staff are caring and attentive.

The service has addressed six of six shortfalls from the previous certification audit. These relate to care plan interventions; on-call staff being informed of all incidents, family communication following incidents is documented; corrective actions; safe storage of chemicals and use of enablers is documented and monitored.

This audit identified improvements required around conducting weekly checks of controlled drugs and registered nurses completing medication administration competencies.

Audit Summary as at 22 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

Indicator	Description	Definition
	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 22 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.
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Organisational Management as at 22 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.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 22 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.
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Safe and Appropriate Environment as at 22 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.
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Restraint Minimisation and Safe Practice as at 22 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.
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Infection Prevention and Control as at 22 January 2014

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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:	Seniorcare Geraldine Incorporated		
Certificate name:	Seniorcare Geraldine Incorporated		
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited		
Types of audit:	Surveillance Audit		
Premises audited:	Waihi Lodge Care Centre		
Services audited:	Rest home care (excluding dementia care)		
Dates of audit:	Start date: 22 January 2014	End date: 22 January 2014	
Proposed changes to current services (if any):			
Total beds occupied across all premises included in the audit on the first day of the audit:			16

Audit Team

Lead Auditor	XXXXX	Hours on site	8	Hours off site	5
Other Auditors		Total hours on site	0	Total hours off site	0
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	8	Total audit hours off site	6	Total audit hours	14
Number of residents interviewed	6	Number of staff interviewed	5	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)	27	Number of relatives interviewed	1
Number of residents' records reviewed using tracer methodology	1			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of 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	Yes
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, 13 February 2014

Executive Summary of Audit

General Overview

Seniorcare Geraldine Incorporated are the proprietors of Waihi Lodge care centre – situated in Geraldine, South Canterbury. The facility is managed by an enrolled nurse who reports to the chairman of the governing board. The service is certified to provide rest home level care for up to 19 residents with a current occupancy of 16 residents. The service continues to implement a system of continuous quality improvement and residents and family spoken to advised that the staff are caring and attentive.

The service has addressed six of six shortfalls from the previous certification audit. These relate to care plan interventions; on-call staff being informed of all incidents; family communication following incidents is documented; corrective actions; safe storage of chemicals and use of enablers is documented and monitored.

This audit identified improvements required around conducting weekly checks of controlled drugs and registered nurses completing medication administration competencies.

Outcome 1.1: Consumer Rights

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion were viewed in reception area of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet.

Outcome 1.2: Organisational Management

Waihi Lodge care centre has a current business and quality plan to support quality and risk management. Quality information is gathered from internal audits, incidents and accidents, feedback from residents, family and staff. Data is collected and collated to provide opportunities for improvement. Resident/relative surveys are undertaken annually. Staff requirements are determined using an organisation service level/skill mix process and documented. Duty schedules are available for all shifts. Staffing rosters indicate there is suitable staff on duty to care for residents. The service has a documented training plan. The service has addressed and monitored shortfalls from previous certification audit around corrective actions, and evidencing that family are notified following incidents and accidents.

Outcome 1.3: Continuum of Service Delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission using the interRAI assessment tool. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Support plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing support plans. Support plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. The service has addressed and monitored previous shortfalls relating to care plans describing the interventions required to meet identified goals and

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	Stock checks of controlled drugs are conducted by two staff members at random intervals – not routinely on a weekly basis.	Conduct weekly documented checks of controlled drugs as per guidelines.	90
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 Low	Medication competency has not been completed for the registered nurse or relieving registered nurse.	Provide evidence that all staff with responsibilities for administering medications are competent to do so. Registered nurses to complete medication competency.	30

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:

There is an open disclosure policy in place, information on which is included at the time of admission. The policy states residents or their representative have the right to full and open disclosure. Incident and accident forms are completed by either caregivers or the registered nurse and a copy of any incident relating to individual residents is included in the clinical file. A communication sheet records that families are informed following general practitioner (GP) review, incidents or accidents or if there is a change in resident condition (confirmed by one relative interviewed). Notification of next of kin for the incident reports sampled was confirmed through the clinical files reviewed. Copies of completed admission agreements are held in the manager's office and an extensive admission booklet is given to all new residents and or family. There is an interpreter policy in place with information included in the admission booklet. Non-Subsidised residents are advised of the process and eligibility to become a subsidised resident through the admission booklet. The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the admission agreement and admission booklet. Residents (six) and relatives (one) interviewed, confirmed they are kept fully informed. The admission booklet is available in large print and can be read to residents if required.

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

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: <p>The complaints process and forms for completion are available at the entrance foyer of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received for the past 12 months was conducted. A record of outcomes is recorded within a complaints register. The complaints register records the details of the complaint, date of corrective actions taken and signed off when resolved. The facility manager maintains the records of all complaints that are processed as evidenced by the two complaints received for 2013. Details of the management of the complaints is recorded including letters of follow up and response. Complaints are discussed at the monthly quality improvement meetings, and at the general staff meetings. D13.3h. a complaints procedure is provided to residents within the information pack at entry.</p>

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

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

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: Seniorcare Geraldine (Inc.) are the proprietors of Waihi Lodge Care Centre in Geraldine. The facility manager is an enrolled nurse and maintains an annual practicing certificate. She has qualifications in rest home management and general management. The facility manager reports to the governing board on a monthly basis on a variety of topics relating to quality and risk management. The manager has been in the role for the past 29 years and is supported by the board, a registered nurse and care staff. The service has a current strategic and business plan which includes a current quality and risk management plan for July 2013 – June 2014. A quality management system is implemented which includes gathering data and information to provide opportunities for quality improvement. The organisation has a philosophy

of care which includes the mission statement: “our aim is to provide a high quality standard of care and service by forming partnership with residents and their families”. The facility manager has attended in excess of eight hours of professional development in the past 12 months relating to managing a rest home and includes attending regular aged care providers meetings, nursing professional development and a session relating to legal issues in aged care.

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA

Evidence:

The Seniorcare Geraldine (Inc.) board has a documented constitution as proprietors of Waihi Lodge care centre. Waihi Lodge has a current quality and risk management plan for July 2013 – June 2014 which includes a quality policy statement, and goals and objectives. The current objectives include education for staff, maintaining competent staff, meeting contractual requirements, and providing meaningful activities for residents. Other objectives include quality improvement activities, monitoring performance and maintaining effective communication.

Quality improvements for Waihi Lodge have also been documented and are developed as a result of feedback from residents and staff, audits, complaints and incidents and accidents. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning.

Progress with the quality and risk management plan is monitored through the two monthly quality improvement committee meetings, and monthly general staff meetings. Monthly and annual reviews are completed for all areas of service and include infection rates, incidents and accidents, restraint use, internal audits, wounds, complaints, and health and safety. The two monthly quality committee meeting agenda includes (but is not limited to): previous meetings minutes, food service, infection surveillance, complaints, laundry service, health and safety, occupancy, restraint, audits, quality goals, and policy and procedure review. Minutes are maintained (sighted for 11 December 2013) and staff have access to these meeting minutes in the nurses' station (confirmed by two caregivers at interview). Staff meetings agenda includes a report from the quality committee, internal audits, general housekeeping, and is followed by an education session (minutes sighted for November 2013). Minutes for all meetings include actions to achieve compliance where relevant. This, together with staff training, demonstrates Waihi Lodge's commitment to on-going quality improvement. Discussions with one registered nurse and two caregivers confirm their involvement in the quality programme. Resident/relative meetings take place three monthly with laundry, activities and food/meals as regular agenda items. Minutes sighted for October 2013.

There is an internal audit schedule. It includes (but is not limited to): risk management, restraint use, care planning, continence, food services, fire drill, standard precautions, medication management, workplace inspection, hand hygiene, resident handling and transfers, admissions, and infection control.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. The director of SOP, the clinical nurse advisor and the policies and procedures CQI work stream is responsible for development and review of policies and procedures. Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.

There are procedures to guide staff in managing clinical and non-clinical emergencies and implemented risk management, health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, increased supervision and monitoring and sensor mats if required.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by care givers and given to the registered nurse who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the registered nurse and/or facility manager who completes any additional follow up. The facility manager collates and analyses data to identify trends. Results are discussed with staff through the two monthly quality meetings, and monthly staff meetings. Internal Audits for 2013 have been completed and there is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. A

resident survey (August 2013) and a family survey (August 2013) is conducted annually. The surveys evidences that residents and families are over all very satisfied with the service. Survey evaluations have been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via the facility newsletter. Corrective actions are developed following all meetings, audits, surveys, with evidence of actions completed and sign off of all required interventions. The service has made improvements in this area.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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: FA
Evidence: <p>There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at two monthly quality committee meetings which incorporates health and safety, and monthly general staff meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and one family member interviewed stated they are informed of changes in health status and incidents/accidents. A sample of nine incidents for December 2013 for five residents (one with two falls, one with one fall and one skin tear and one with challenging behaviours) were reviewed. Reports were completed and family notified as appropriate. There is documented evidence of clinical follow up by a registered nurse with review of all reports by the facility manager. Referral to general practitioner has been instigated as required. Medication errors are also reported. A monthly accident and incident review and summary is compiled by the facility manager with subsequent analysis and investigations. Incidents and accidents are reported in progress notes and communication with family regarding incidents is also recorded. Staff have received education regarding incident reporting and communication with families. The service has addressed and monitored this previous finding.</p>

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

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

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

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

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

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

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: The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurses, and general practitioners is kept. There are comprehensive human resources policies including recruitment,

selection, orientation and staff training and development. Five staff files were reviewed (one registered nurse and three caregivers). Advised that reference checks are completed before employment is offered as evidenced in one recently employed staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Two caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in five of five staff files reviewed.

Discussion with the facility manager, one registered nurse and two caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and a plan for 2014. The annual training programme exceeds eight hours annually. Caregivers have completed either the national certificate in care of the elderly or are working towards completion. The facility manager and registered nurse attend external training including conferences, seminars and sessions provided by the local DHB. The facility manager attends a two monthly provider meeting in Timaru with the DHB which includes education and training related to managing the facility.

Education provided in 2013 includes: end of life care, stress management, medication management, fire safety, abuse and neglect, wound care, infection control, pain management, restraint and challenging behaviours. Fire evacuation drill last conducted 11 December 2013. Annual appraisals are conducted for all staff as evidenced in five of five files reviewed.

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

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:

Human resource manual includes a staff rationale and skill mix policy. Sufficient staff are rostered on to manage the care requirements of the rest home residents. A minimum of one staff are rostered on at any one time with either the registered nurse or facility manager providing on-call after hours and weekends. Roster includes: facility manager 40 hours per week and one registered nurse for 36 hours per week. There are five care givers rostered on, each working short shifts, on a morning at Waihi Lodge. In the afternoon there are two caregivers and one caregiver on overnight. The service also employs cleaning staff, cook and kitchen hands and a gardener. Interviews with one registered nurse, two caregivers, six residents and one family members identify that staffing is adequate to meet the needs of residents.

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

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

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; D16.5cj; 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:

An interRAI long term care facility (LTCF) support plan is developed by the service's registered nurse (RN) following completion of the interRAI assessment. The registered nurse is also responsible for maintaining and reviewing the support plans. Fifteen of the current 16 residents have been reassessed by the registered nurse using the interRAI assessment tool. Two of 16 files are yet to be reassessed using interRAI, however, these residents have current assessments completed using the facility's suite of assessment tools. An initial assessment and the beginning of the development of the residents care plan is expected to occur during admission. The full support plan is developed within three weeks. The LTCF plans are developed in consultation with other relevant people including residents and where appropriate family/whanau. There was evidence of other allied health services input at the admission process i.e. general practitioner, dietitian, and podiatrist. One family member interviewed confirmed their involvement and this involvement was documented. Review of five resident files indicated that these time frames were worked within. Care givers complete progress notes at the end of each shift, with registered nurse entries supporting as required. There is an appropriate hand-over briefing between shifts that staff were able to fully describe.

The five files reviewed identified that in all five files an initial assessment was completed within 24 hours and all five files identify that the long term support plan was completed within three weeks. There is documented evidence that the support plans are reviewed by the RN and amended when current health changes. All five support plans evidenced evaluations completed at least six monthly and have had the interRAI assessment completed. The five resident files reviewed identified that the GP had seen the resident within two working days. It was noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly. The interRAI assessment is completed to identify the care assessment protocols (CAP's) on which to base the long term support plan. A daily support plan is also documented to cover all activities of daily living.

A short term care plan (special needs care plan) is completed by the registered nurse for changes in health status eg chest infections, urinary infections, and wound care. Five resident files sampled.

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 1.3.5: 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: FA

Evidence:

Previous audit identified improvement was required in relation to the level of care described in lifestyle support plans to meet the identified goals. In five resident files reviewed there is a long term comprehensive support plan and a daily support care plan implemented for all areas of care needs based on the interRAI assessment completed. Lifestyle support plans demonstrate service integration. Resident files include lifestyle support plans, short term care planning, notes by GP and allied health professionals, significant events, communication with families and notes as required by a registered nurse. This previously identified shortfall has been addressed and monitored.

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: 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:

Overall, the LTCF support plans are completed comprehensively and are personalised and individual to the resident. The care being provided is consistent with the needs of residents. This is evidenced by discussions with two caregivers, six residents and one family members, one registered nurse and one facility manager. There is a short-term care plan (specific needs care plan) that is used for acute or short-term changes in health status. Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include an assessment for continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-service and wound management in-service was provided in 2013. Wound assessment and wound management plans are in place for one resident. The registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. Lifestyle support plans are goal oriented and reviewed six monthly for rest home and hospital residents. A monthly nursing summary is also conducted for all residents and this review prompts changes to the long term care plan if required. Previous shortfall identified relating to communication of all incidents and accidents and recording of same has been addressed and monitored. Staff have received education relating to management and communication to on-call staff member regarding incidents and accidents which occur after hours. Progress notes reviewed for five residents evidence that good records are maintained relating to incidents and accidents and the management of same. During the tour of facility it was noted that all staff treated residents with respect and dignity – six residents and one family members were able to confirm this observation. GP interviewed confirmed that staff are prompt at communicating changes in resident health status and complete interventions as requested.

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

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: Five resident files reviewed evidenced resident social profiles, assessment and activity interests, including individual goals in relation to activities. A comprehensive resident social profile is completed on admission. There is an activities coordinator who works 15 hours per week and has been in the role for six years. The activities programme covers five days a week. There is a weekly plan of activities, based on assessed needs and wishes of the resident, and displayed in the reception area notice board. Resident meetings occur three monthly with activities as an agenda item. Residents are encouraged to participate in activities in the community. There is a wide range of activities offered, that reflect the resident needs including but not limited to: newspaper reading, communion, church services, and exercises, visiting entertainment, seasonal celebrations, music, quizzes games, happy hour, van outings, bowls, library service and visits to other rest homes. The activity

programme is developed with the residents (and relatives) and this is reviewed monthly by the activities coordinator and facility manager. A monthly newsletter is provided for residents and family and includes all upcoming activities. The annual satisfaction survey includes feedback around the activities programme. The activities coordinator provides a three monthly report to the facility manager who in turn provides this to the Seniorcare Geraldine board for Waihi Lodge.

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

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: All initial support plans are evaluated by the registered nurse and a lifestyle support plan developed within three weeks of admission. All five files evidence that long term support plans are evaluated at least six monthly and a monthly nursing summary is also completed. There is evidence that the overall support plans have been reviewed and documented in the evaluation section of each corresponding aspect of the lifestyle support plan. The support plan evaluations indicate the degree of achievement of goals and objectives. The registered nurse, care givers, other health professionals (as appropriate) resident and family are involved at the time of support plan review. GP advised that resident reviews and medication chart reviews are conducted every three months or more frequently as required.

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

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

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

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

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: There are comprehensive medication management policies and procedures in place. Medications are managed appropriately in line with accepted guidelines. The service uses four weekly blister pre-packed medication packs for all residents at Waihi Lodge. Medication charts have photo ID's.

There is a signed agreement with the supplying pharmacy. The registered nurse advised that the list of medications printed on the back of medication packs are checked and reconciled against medication charts upon arrival to the facility and signed off when this check has been completed.

There is one medication trolley at Waihi Lodge which is stored in a locked medication room. The registered nurse was observed safely administering medications at lunch time - checking the medication chart, the medico pack and then observing the resident taking the medication and completing documentation.

There is a list of standing order medications that have been approved by the GP's for each individual resident. Staff sign for the administration of medications on medication sheets held with the medicines. A list of specimen signatures and competencies for staff responsible for medication management is maintained. There is one locked safe for controlled drugs and a controlled drug register maintained for the safekeeping and administration of controlled drugs for residents. Controlled drugs are checked in to the locked safe by the registered nurse and a medication competent staff member, and six monthly physical stocktakes are conducted by Pharmacist. Controlled drug books shows evidence of two signatures for all controlled drug administration. Stock checks of controlled drugs are conducted by two staff members at random intervals – not routinely on a weekly basis. Improvements are required in this area. There are minimal stock drugs kept on the premises. The medication fridge temperatures are monitored daily. The registered nurse administers medications when she is on duty and medication competent care givers administer medications at other times. Medication education and competencies are completed for caregivers. The registered nurse assesses care staff for medication competency which includes questions and observation. Medication competency has not been completed for the registered nurse or relieving registered nurse. Improvement is required in this area. Unused medications and expired medications are returned to pharmacy. Medication charts for 10 residents were reviewed. There is evidence of GP reviewing medication charts for each resident three monthly - confirmed at GP interview. Allergies are recorded in the medical admission sheet, and on the medication charts. The service records all medication errors as incidents/accidents and these are followed up and reported to staff meetings and quality improvement meetings. The service has a policy and procedure on residents who wish to self-medicate that eludes three monthly assessments by GP of the resident's on-going ability to safely self-medicate and a resident competency review form. There are currently no residents self-medicating at Waihi Lodge. Medication policy and procedures direct staff in the safe management of medications at Waihi Lodge.

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: There is one medication trolley at Waihi Lodge which is stored in a locked medication room. The registered nurse was observed safely administering medications at lunch time - checking the medication chart, the medico pack and then observing the resident taking the medication and completing documentation. There is a list of standing order medications that have been approved by the GP's for each individual resident. Staff sign for the administration of medications on medication sheets held with the medicines. A list of specimen signatures and competencies for staff responsible for medication management is maintained. There is one locked safe for controlled drugs and a controlled drug register maintained for the safekeeping and administration of controlled drugs for residents. Controlled drugs are checked in to the locked safe by the registered nurse and a medication competent staff member, and six monthly physical stocktakes are conducted by Pharmacist. Controlled drug books shows evidence of two signatures for all controlled drug administration. There are minimal stock drugs kept on the premises.
Finding: Stock checks of controlled drugs are conducted by two staff members at random intervals – not routinely on a weekly basis.
Corrective Action: Conduct weekly documented checks of controlled drugs as per guidelines.
Timeframe (days): 90 (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 Low
Evidence: The registered nurse was observed safely administering medications at lunch time - checking the medication chart, the medico pack and then observing the resident taking the medication and completing documentation. A list of specimen signatures and competencies for staff responsible for medication management is maintained Medication education and competencies are completed for care givers. The registered nurse assesses care staff for medication competency which includes questions and observation.
Finding: Medication competency has not been completed for the registered nurse or relieving registered nurse.
Corrective Action: Provide evidence that all staff with responsibilities for administering medications are competent to do so. Registered nurses to complete medication competency.
Timeframe (days): 30 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>Waihi Lodge care centre has a well-run food service that is managed by an experienced kitchen supervisor. All meals for residents are prepared and cooked on site. The main cook has been in the role for many years and advised that she and other kitchen staff have completed food safety qualifications.</p> <p>The five weekly menu is designed by the facility manager with previous dietitian review conducted.</p> <p>Improvement note: consider regular dietitian review in line with industry best practice to evidence that all nutritional requirements for elderly residents are catered for.</p> <p>The kitchen also provides meals on wheels to the community and has a current Timaru District Council food service certificate which expires on 30 June 2014.</p> <p>The food service is notified of dietary requirements via a dietary requirements form which is completed by the registered nurse and sent through to the kitchen. It includes likes and dislikes, modified diets and preferences. The service provides special equipment e.g. utensils, lip plates and sipper cups as required. Meals are served directly to residents from the kitchen to the adjoining dining room. Food temperature recordings are taken randomly for hot dishes prior to serving. Fridge and freezer temperatures are monitored daily and recorded weekly. There are two large fridges, and a large freezer. Food stored in the fridges and freezer is covered and labelled and dated. The kitchen pantry has extra food stores - enough for three days if required in an emergency, including adequate water supply. The service has access to a generator in the event of power failure which is able to maintain power to fridge and freezers and operate the oven and cook tops. A gas BBQ is also available.</p> <p>The registered nurse conducts nutritional assessments on all residents as part of interRAI assessment tool. A dietitian is available if required for residents with weight issues. Weights reviewed in five resident plans identified that weights are monitored and are stable. Information is documented in the daily support plan interventions, and in the LTCF support plan if there is an identified nutritional issue. Resident weights are monitored monthly or more frequently if required. Six residents interviewed were complimentary of the food service.</p>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: FA
Evidence: The facility displays a current building warrant of fitness which expires on 1 July 2014. A fire evacuation scheme was approved by the New Zealand Fire Service in June 1996.

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.)

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:

Previous certification audit identified that not all chemicals were stored securely – the laundry/sluice room was not locked and chemicals were observed on the cleaner’s trolley and on a shelf in this room. It is noted that the laundry/sluice room is now locked and chemicals were not observed to be unsecure. The service has made improvements in this area.

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.)*

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:

There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. The service is restraint free and has been since 2009. There are no residents using enablers. Policy dictates that enablers should be voluntary and the least restrictive option possible. The facility manager, one registered nurse (restraint coordinator) and two care givers are familiar with this. The service has monitored and addressed the previous certification shortfall relating to documentation of a resident with an enabler. Advised by the registered nurse that this shortfall was addressed immediately and there is documentation available for future residents who require enablers. Restraint/enabler use is discussed at quality improvement meetings, and at staff meetings. Restraint use audit conducted December 2013.

Staff received training around restraint minimisation and safe practice in December 2013. Management of challenging behaviours education was provided as part of this session. Restraint questionnaires and competency are also completed for all care staff. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers.

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:

Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the two monthly quality improvement meetings, and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager and to organisational management. The registered nurse is the designated infection control nurse and has attended infection control training in 2013.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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