

# Nazareth Rest Home Limited

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Current Status: 11 November 2013

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

## General overview

Nazareth Rest Home provides care for up to 46 residents at either rest home or hospital level care. At the time of the audit, there are 46 rest home level residents. The manager has been in the position for seven years and has nine years prior management experience in the DHB. The clinical nurse leader who has worked in rest homes for 13 years supports the manager.

Nine of the 11 improvements required at the previous audit have been addressed. These were around advanced directives, the quality and risk management programme, human resources, food services, the call system, documentation of wound management and documentation of medication administration.

Two shortfalls identified at the certification audit continue to require improvement; these are around assessments and interventions.

Further improvements are also required around medication management.

## Audit Summary as at 11 November 2013

Standards have been assessed and summarised below:

### Key

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk
	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 11 November 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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### Organisational Management as at 11 November 2013

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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### Continuum of Service Delivery as at 11 November 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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### Safe and Appropriate Environment as at 11 November 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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### Restraint Minimisation and Safe Practice as at 11 November 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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### Infection Prevention and Control as at 11 November 2013

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

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## 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

<b>Legal entity name:</b>	Nazareth Rest Home Limited
<b>Certificate name:</b>	Nazareth Rest Home
<b>Designated Auditing Agency:</b>	HDANZ
<b>Types of audit:</b>	Surveillance
<b>Premises audited:</b>	14 Hillside Terrace, St Johns Hill, Wanganui
<b>Services audited:</b>	Rest home
<b>Dates of audit:</b>	<b>Start date:</b> 11 November 2013 <b>End date:</b> 11 November 2013
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	46

## Audit Team

<b>Lead Auditor</b>	XXXXX	<b>Hours on site</b>	8	<b>Hours off site</b>	7
<b>Other Auditors</b>	XXXXX	<b>Total hours on site</b>	8	<b>Total hours off site</b>	7
<b>Technical Experts</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Consumer Auditors</b>		<b>Total hours on site</b>		<b>Total hours off site</b>	
<b>Peer Reviewer</b>	XXXXX			<b>Hours</b>	1.5

## Sample Totals

Total audit hours on site	16	Total audit hours off site	15.5	Total audit hours	31.5
Number of residents interviewed	5	Number of staff interviewed	7	Number of managers interviewed	1
Number of residents' records reviewed	4	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	8	Total number of staff (headcount)	52	Number of relatives interviewed	3
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 the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Friday, 31 January 2014

## Executive Summary of Audit

### General Overview

Nazareth Rest Home provides care for up to 46 residents at either rest home or hospital level care. At the time of the audit, there are 46 rest home level residents. The manager has been in the position for seven years and has nine years prior management experience in the DHB. The clinical nurse leader who has worked in rest homes for 13 years supports the manager.

Nine of the 11 improvements required at the previous audit have been addressed. These were around advanced directives, the quality and risk management programme, human resources, food services, the call system, documentation of wound management and documentation of medication administration.

Two shortfalls identified at the certification audit continue to require improvement. These are around assessments and interventions.

Further improvements are also required to around medication management.

### Outcome 1.1: Consumer Rights

Nazareth Rest Home provides care and support that focuses on the individual with residents and relatives praising the services provided. Family state that they are informed of any incidents. Complaints processes are implemented, complaints, and concerns are actively managed and documented with a complaints register completed by the manager. The service encourages the documentation of verbal complaints as a tool to improve quality of service delivery.

Improvements required at the previous audit around advanced directives have been addressed.

### Outcome 1.2: Organisational Management

Nazareth Rest Home provides rest home and hospital level care noting that there are currently no hospital residents yet in the service. There is a quality and risk management programme implemented with management and use of quality data to improve service delivery. This includes review of incidents, accidents, hazards; internal audits; infections; complaints; and resident/family satisfaction surveys. An internal audit schedule is implemented.

Improvements required at the previous audit around the risk management plan, personalisation and implementation of the quality programme, checking of references for new staff, documentation of a roster for hospital residents and recruitment of staff should hospital residents be admitted have been addressed.

### Outcome 1.3: Continuum of Service Delivery

The registered nurses complete assessments, care plans and evaluations. Residents/relatives are involved in planning and evaluating care. Residents and relatives interviewed comment positively on the care delivered at Nazareth home. Risk assessment tools and monitoring forms are available. There continues to be an improvement required around the review of risk assessments and documentation of interventions in care plans.

Care plans demonstrate service integration. Short term care plans are in use for changes in health status. Care plans are evaluated six monthly. The diversional therapist provides an activities programme for the residents that is varied, interesting and involves families, volunteers, pastoral care and community.

Staff responsible for the administration of medication are competency assessed annually. There is an improvement required around medication education.

There have been improvements made in regards to medication documentation for regular medications. However, an improvement is required around



## Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.4: Assessment	Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low			
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 Low	i) An intermediate care resident did not have risk assessments reviewed on the second intermediate care admission. ii) There has been no review of risk assessments including pain assessment for one rest home resident since admission eight months ago.	i) Ensure risk assessment tools are completed for each episode of short term care. ii) Ensure all risk assessment tools are reviewed six monthly.	60
HDS(C)S.2008	Standard 1.3.6: Service Delivery/Interventions	Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low			
HDS(C)S.2008	Criterion 1.3.6.1	The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	There has been no disturbing behaviour assessment or disturbing behaviour monitoring in place for one resident with challenging behaviour that is escalating over the past two months. There is no documentation that reflects the specific behaviours reported in progress notes and incident forms. The improvement identified at the previous audit	Ensure that care plans document specific care and interventions for challenging behaviours as noted through progress notes and incident forms.	60

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				regarding the documentation of interventions remains an issue at this audit.		
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 Low			
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	Two medication competent caregivers were not signing the controlled drugs signing administration form. This was corrected on the day of the audit.	Ensure two medication competent persons to sign the controlled drugs signing administration form.	60
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	There not been any formal medication education within the last two years. Since the draft report, the service advised that training on medicine management was held and has been undertaken by 18 caregivers	Ensure medication competent persons receive formal medication education annually.	90

## Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding



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

## Outcome 1.1: Consumer Rights

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on first contact with the family/resident.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement through the agreement and in discussion with the manager or clinical nurse leader.

D16.4b Three of three relatives state that they are always informed when their family members health status changes.

The facility has an interpreter policy and procedures available for access to interpreter services and residents (and their family) are provided with this information at the point of entry. Interpreters are available through the DHB if required. There have been no residents who require interpreting services.

D11.3 The information pack is available in large print if required and advised that this can be read to residents.

Five of five residents interviewed and three of three family members interviewed state that there is excellent communication with the manager, clinical nurse leader and other staff.

All family members' state that they are informed when there is an incident and the incident forms reviewed (20 of 22 reviewed) reflect this.

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

The policy around advanced directives and resuscitation policy is implemented. Four resident files sampled contained appropriately completed resuscitation orders signed by the resident only. The previous shortfall has been addressed.

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

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

**Attainment and Risk:** FA

**Evidence:**

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<p><b>Evidence:</b></p> <p>D13.3h. The service has complaints management policies and procedures in place and residents are provided with information on the complaints process on admission through the information pack.</p> <p>D13.3g: The complaints procedure is provided to relatives on admission as confirmed by three of three families interviewed.</p> <p>The complaint process is in a format that is readily understood and accessible to residents/family.</p> <p>Staff including the three caregivers and an enrolled nurse interviewed are aware of the complaints process and to whom they should direct complaints.</p> <p>Residents and family confirm they are aware of the complaints process and they would make a complaint to the manager if necessary.</p> <p>Five of five residents interviewed and three family members state that they have no complaints nor have they had the need to complain about anything in the past.</p> <p>There is a comprehensive complaints register in place. Two complaints reviewed in 2013 are documented on the complaints register and all tracked indicate that resolution and a letter to the complainant have been completed in a timely manner.</p> <p>The manager confirms that there have been no complaints in the past three years with the Health and Disability Commissioner, MoH or DHB.</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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>

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

**Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

## Outcome 1.2: Organisational Management

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

Nazareth Rest Home provides care for up to 46 residents at rest home or hospital level care. At the time of the audit, there are 46 rest home residents including seven under the continuing care contract including two identified as non-weight bearing.

The manager has been in the position for seven years and has nine years prior management experience in the DHB. She has a Grad Dip Business Studies and is supported by a clinical nurse leader who has a current annual practicing certificate. The clinical nurse leader is an experienced registered nurse who has worked in rest homes for 13 years.

ARC, D17.3di (rest home): The manager has maintained at least either hours annually of professional development activities related to managing a rest home. The clinical nurse leader also has over eight hours professional development hours completed in 2013.

There are two directors of Nazareth, one an accountant and one a Sister of St Joseph. The manager reports to the directors who in turn report to the board (managers reports sighted for October and November 2013). The reports include financial statements.

The directors and the manager set the philosophy of the service, which is 'a caring happy community'. Nazareth's mission and vision flow from the vision of the Sisters of St Joseph which is 'fullness of life for the earth and its peoples - kii tonu te ao me te orokohanga a te tangata'.

There is a business plan which is reviewed annually (currently in the process of being reviewed with notes documented on the plan as goals have been reached). All five residents and three family praised the leadership and operational management of the manager and stated that the manager lives and breathes the philosophy and therefore the staff do as well.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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:

D19.1a; A review of the documentation, policies and procedures and from discussion with the manager, clinical nurse leader, three caregivers and an enrolled nurse identifies that there are service operational management strategies and an implemented quality and risk programme which includes individually appropriate care. The manager provides oversight of the quality programme with the clinical nurse leader taking a key clinical role. The meeting structure and audit schedule along with policies and procedures have been reviewed in 2013.

There is a document control process in place for all policies.

D5.4 The service has the following policies/ procedures to support service delivery; continence, challenging behaviour, pain management policy and procedure, personal grooming and hygiene policy, skin, wound care policy and procedures. Transportation of subsidised residents policy and procedure includes costs, resident, and staff safety.

D10.1 There is a death policy and procedure that outlines immediate action to be taken upon a resident death and that all necessary certifications and documentation is completed in a timely manner.

The three caregivers and an enrolled nurse interviewed state that any new caregiver receives an orientation that includes reading of the policies - orientation records signed off in all five staff files reviewed.

The service has an implemented internal audit programme and when issues are identified, there is evidence in the monthly quality and monthly staff meeting minutes that these are followed up and issues resolved. The set agenda at these meetings ensures that all aspects of the quality and risk programme are discussed i.e. infections and infection control, complaints, incidents and accidents, staff, resident issues. There is also a two monthly registered nurse meeting with the clinical nurse leader facilitating this. These focus predominantly on resident issues and clinical care and aspects of the quality and risk management programme relevant to the care are included in the meetings.

Resident meetings are held six weekly. Family are invited to attend. Any actions are documented on a quality improvement plan and there is evidence of resolution.

There is a risk management register and hazards documented. A review of these indicates that these are signed off when resolved. A list of current hazards is kept with actions implemented to proactively prevent accidents.

Residents and family complete an annual satisfaction survey last completed in December 2013 and this is currently being collated.

D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management

D19.2g Falls prevention strategies such as sensor mats, increased supervision and low beds. Relevant residents have these strategies identified in care plans and staff including the three caregivers, enrolled nurse and clinical nurse leader are able to describe individual residents and strategies implemented.

Corrective action plans are documented for any issues identified and signed off as resolved in a timely manner.

Residents and family interviewed can describe improvements in the service over the past year.

There is a folder kept of improvements and in 2013, these have included the following: review of shifts, updating of kitchen processes, updating of equipment, toolbox meetings to set priorities and timelines for staff, review of the heated food deliveries, review of power outage management, updating of emergency call bells.

A risk management plan has been documented 2013-14 with review of the previous plan completed in January 2013. The previous shortfall has been addressed.

The service has now had an opportunity to personalise and implement the quality programme initially purchased from an external consultant. The previous shortfall has been addressed.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> D19.3b; There is an incident and accident policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Incidents/accidents are investigated and analysis of incidents trends occurs monthly. There is a discussion of incidents/accidents in the quality management meetings monthly and discussion for staff at staff meetings. Relevant issues are also discussed as they relate to residents at the registered nurse meetings held every two months. Discussions with the manager and the clinical nurse leader confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A review of 22 incident forms indicate that all have been signed off by the clinical nurse leader and/ manager and all indicate that family have been informed apart from two which did not indicate that the family had been notified (both forms not signed are for one resident with continuing challenging behaviours – at other times family is notified).

#### 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.

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> Five staff files were reviewed including the clinical nurse leader, one registered nurse and three caregivers.

D17.7d: There are implemented competencies for all relevant caregivers and registered nurses around medication and evidence in staff files confirms that these have been completed for relevant staff. Other questionnaires are completed for training with other competencies also completed e.g. for restraint and enablers. Current practicing certificates are sighted for the clinical nurse leader, all registered nurses, the enrolled nurse, doctors, dietician and physiotherapist. Five of five staff files include a signed contract, application form, evidence of training, referee checks, police checks and job description. Five of five files reviewed indicate that staff have completed an orientation programme that is relevant to support for people using rest home and hospital level care with the service having a low turnover rate. Caregivers have completed ACE, Careerforce or national certificate for aged care training. The manager and clinical nurse leader confirm that they have completed at least eight hours training a year (training records sighted for the clinical nurse leader indicates that there are completed training days with the DHB and with other key providers). Five of five residents including one under the continuing care contract interviewed and three of three family members interviewed state consistently that staff are competent, caring and knowledgeable with care provided using a spiritual philosophy of caring and respect. There is an annual training plan and three caregivers and enrolled nurse confirm that they find the training valuable. They also praised the ability of the manager and clinical nurse leader to bring in relevant services to provide training e.g. a recently held talk around Parkinson's is described as giving the caregivers and enrolled nurse a greater understanding of cares required. There is a folder with the content of the training sessions kept and an individual staff record of training. Two new staff files reviewed indicates that the recruitment process also includes completion of reference checks for staff. The previous shortfall has been addressed.

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

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

**Attainment and Risk:** FA

### Evidence:

The staffing and skill mix policy includes a section on staffing levels rationale and is based on Ministry of Health guidelines. It is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of residents. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

The service contracts with allied health professionals on an as required basis.

Staffing is as follows (46 of 46 residents):

Monday-Friday manager 08.30-18.00 - also on call 24 hours per day with the clinical nurse leader providing Monday to Friday 7.30am-4pm. There a registered nurse on duty Friday to Sunday from 7.30am-4pm. The service has continued to employ the additional registered nursing staff to strengthen the nursing base allowing for appropriate sick leave and weekend cover. Auxiliary staff are as follows:

Personal assistant - 33 hours per week, Monday to Friday, administrator - 33 hours per week, Monday to Friday, pastoral carers - 20 hours per week X two people (total 40 hours), diversional therapist - 37.5 hours per week, cooks - 6 hours per day X 7 days, kitchen hands - 10.5 hours per day X 7 days, cleaning staff - total of 60 hours per week over seven days, laundry staff - total off 21 hours per week over 7 days, maintenance - 40 hours per week and gardens - 30 hours per week.

Caregivers are rostered as follows (rosters sighted):

AM: Two caregivers full shift and five short shift.

PM: Two caregivers full shift and two short shift.

Night: Two caregivers from 2330 - 0730 hours.

Five of five residents interviewed report there are always enough staff on duty and all praised the staff for the care and support provided.

Staff turnover is low.

A roster and rationale for hospital staffing is developed noting that there are no hospital residents to date. The previous shortfall has been addressed.

The service has placed an advertisement in the local papers to begin recruitment of three more registered nurses to be able to provide 24-hour registered nurse cover for hospital residents as they are referred. The staffing policy has been updated to reflect the changes in staffing for hospital residents including putting on extra caregivers if required according to acuity of residents. The previous shortfall has been addressed.

### 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; D16.5c.i; 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:**

D16.2, 3, A registered nurse undertakes the assessments on admission, with the initial care plan completed within 24 hours of admission. Within three weeks, the long term care plan is developed as evidenced in two rest home resident files sampled. Short term care plans are developed for intermediate care residents as evidenced in two intermediate care resident files. There is evidence of resident and/or family/whanau/EPOA involvement in the care planning process. The diversional therapist completes an activities assessment involving the resident and their family soon after admission. An activity plan is developed. Care plans are used by nursing staff and caregivers to ensure care delivery is in line with the residents assessed needs.

A range of assessment tools available for use on admission includes (but not limited to); a) dietary profile b) braden pressure area risk assessment, c) continence assessment d) coombes falls risk assessment and fall risk assessment tool e) wound assessment f) pain assessment and g) disturbing behaviour assessment.

There is a verbal handover and written handover sheet for caregivers at the beginning of each shift. Any resident concerns or events are communicated to the oncoming staff. Caregivers could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. The afternoon shift handover is observed.

All four files identified integration of allied health including the GP, community assessment, treatment and rehabilitation team, consultant physician, geriatrician, podiatrist, district nurses, social worker and occupational therapist. Intermediate care residents are followed up by the intermediate care team, which includes the intermediate care RN, occupational therapist, social worker and physiotherapist. The team is based at the DHB. The resident is visited by the GP by referral from the intermediate care team or RN on duty if required.

Medical assessments are completed within 48 hours of admission in two of two rest home resident files sampled. The home GP visits fortnightly. However, residents may choose to retain their own GP. The GP completes routine three month visits and medication reviews. A GP visit stamp in the medical notes identifies a three monthly visit, medication review and blood pressure, pulse and weight recordings. The resident GP visits at any other time for any resident concerns. Residents are referred to the Wanganui accident and emergency services for treatment after 9pm. The GP was unavailable for interview.

Tracer methodology; Rest home resident

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

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

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

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

**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.

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

**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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>

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

**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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> A range of assessment tools are available for use on admission and include (but not limited to); a) dietary profile b) Braden pressure area risk assessment, c) continence assessment d) coombes falls risk assessment and falls risk assessment tool e) wound assessment f) pain assessment and g) disturbing behaviour assessment. Assessments viewed in four of four resident files sampled (two rest home residents and two intermediate care residents) are dated and signed which is an improvement since the previous audit. Residents under intermediate care have weekly visits by the assessment team and also an in-house short term care plan. The shortfall from the previous audit regarding the implementation and review of risk assessments remains.

**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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> A range of assessment tools are available for use on admission and include (but not limited to); a) dietary profile b) Braden pressure area risk assessment, c) continence assessment d) coombes falls risk assessment and falls risk assessment tool e) wound assessment f) pain assessment and g) disturbing behaviour assessment. Assessments viewed in four of four resident files sampled (two rest home residents and two intermediate care residents) are dated and signed which is an improvement since the previous audit. The shortfall from the previous audit regarding the implementation and review of risk assessments remains.
<b>Finding:</b> i) An intermediate care resident did not have risk assessments reviewed on the second intermediate care admission. ii) There has been no review of risk assessments including pain assessment for one rest home resident since admission eight months ago.
<b>Corrective Action:</b> i) Ensure risk assessment tools are completed for each episode of short term care.

ii) Ensure all risk assessment tools are reviewed six monthly.

**Timeframe (days):** 60 (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:** PA Low

#### **Evidence:**

The registered nurse completes residents' support plans. When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. The two caregivers and an enrolled nurse interviewed stated that they have all the equipment referred to in support plans necessary to provide care, including a standing and lifting hoist, pressure area mattresses, hi-low beds, lifting belts, wheelchairs, mobility aids, chair scales, sensor mats, gloves, aprons and masks.

The service has access to physiotherapy services for equipment assessment and advice.

D18.3 and 4 Dressing supplies are available and the treatment room is well stocked. Staff report that there are adequate continence supplies and dressing supplies.

Wound care plans are in place for minor skin tears and a leg ulcer. The wound care plan includes wound assessment detailing a description of the wound, size and location, colour of surrounding skin, exudate, odour, pain and signs of infection. Treatment and evaluation progress notes describe the dressing, healing progress and any GP/specialist input. A non-healing skin tear has been photographed and had GP input. A wound swab has been taken and a referral sighted to the wound care specialist at Wanganui district health board. The district nurses carry out dressings for any wound under ACC. Staff attended in service on skin care and management and wound management September 2013.

Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed through the district health board.

Dietary profile forms that include specific dietary requirement, likes and dislikes are completed on admission for all new admissions. Dietary profiles are reviewed six monthly. Copies are sent to the cook. The cook confirms dietary profiles and any special requests are received from the RN. The cook is aware of any residents with weight loss and a high calorie diet is provided. All residents are weighed monthly and more frequently if there is a need for weight monitoring. Food and fluid charts are implemented for residents with unintentional weight loss. The GP reviews residents weight loss at the three monthly review or earlier if notified of weight loss by the RN. Staff have attended hydration/fluid intake and weigh loss in service March 2013. The dietitian and speech language therapist are readily available by referral to the DHB. The podiatrist visits six weekly.

There has been no disturbing behaviour assessment or disturbing behaviour monitoring in place for one resident with challenging behaviour that is escalating over the past two months. There is no documentation that reflects the specific behavior's reported in progress notes and incident forms. The improvement identified at the previous audit regarding the documentation of interventions remains an issue at this audit. The manager advised that have made modifications from their last audit. They stated that this resident had become the main focus of a multidisciplinary approach to residents with behavioural issues.

### 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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> There is a challenging behaviour policy that describes the use of a disturbing behaviour assessment and disturbing behaviour monitoring form. The service can evidence family have been notified of a residents disturbing behaviour (file sampled) and a family meeting held to discuss re-assessment to a higher level of care. The GP, consultant physician and geriatrician have been involved. The progress notes report incidences and disturbing behaviour. Staff have attended challenging behaviour in-service in February 2013.
<b>Finding:</b> There has been no disturbing behaviour assessment or disturbing behaviour monitoring in place for one resident with challenging behaviour. The improvement identified at the previous audit regarding the documentation of interventions remains an issue at this audit.
<b>Corrective Action:</b> Ensure that care plans document specific care and interventions for challenging behaviours as noted through progress notes and incident forms.
<b>Timeframe (days):</b> 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> The service employs a qualified registered diversional therapist (DT) for 37.5 hours a week from Monday to Friday. An activity assistant works one day a week to allow the DT to complete activity documentation and programme planning. The programme is planned to suit the resident's recreational, spiritual and cultural needs and physical and cognitive abilities. There is a residents meeting held six weekly with good feedback and suggestions for activities, outings and entertainment. The programme is displayed on the notice board and in the facility wings. There are planned activities such as movies for the weekends. There are 30 volunteers involved in a variety of activities with the residents including; house, cards, on site shop, outings, games, inter-home bowls, men's group, crafts, reading for the visually impaired and newspaper reading. Residents are involved in helping with the vegetable garden, feeding the birds and fish, and enjoy baking. Families are invited to social events such as the monthly barbeques, cocktail evenings with entertainment and inter-home sports days co-ordinated by the DT. Pastoral care visitors include the Sisters from the Home of Compassion who visit residents frequently. They provide two open church services in the on-site chapel and a weekly mass. Residents are also supported to attend their own church and maintain their community links with such groups as the arthritis society. The RSA visit annually and more often by resident request. The St Johns club organise dance groups. The residents enjoy visits from the therapy dogs, choirs and young children. There are residents who prefer not to participate in the group activity programme and receive daily contact by the DT or the pastoral visitors. The DT completes an activity assessment as soon as practical after admission of a new resident and develops an activity care plan with resident and family involvement. The care plan is reviewed after three months then six monthly thereafter at about the same time as the clinical care plan. Attendance sheets are maintained. Progress notes are written monthly or when significant events occur into the integrated file and identified by the DT stamp. The DT meets monthly with the clinical nurse leader and pastoral care visitors to discuss any areas of concern and review of care plans.

### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> <p>The RN completes a review of the long-term care plan six monthly. Changes to health status or additional support required is entered onto a short-term care plan, which evaluated regularly. The resident/family are notified of the review and invited to attend. The long-term support plan is amended with each review if there are changes. Problems are resolved or if an on-going problem are added to the long-term care plan. The GP reviews the resident three monthly and reviews the residents weight, blood pressure and pulse and any concerns the RN or resident/family wish to discuss. Intermediate care residents have a short-term care plan in place, which is reviewed regularly in consultation with the intermediate care team.</p> <p>The previous shortfall regarding evaluation of wound care plans has been addressed (link 1.3.6). The wound care plans sighted include wound assessments detailing a description of the wound, size and location, colour of surrounding skin, exudate, odour, pain and signs of infection.</p> <p>D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.</p> <p>ARC D16.3c: the RN evaluated all initial care plans within three weeks of admission.</p>

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

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

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

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

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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> (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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> A pharmacy agreement is in place. All the four weekly blister packs and pharmaceuticals are delivered by the pharmacist and checked by the RN. Any discrepancies are

fed back to the pharmacy. The clinical nurse leader returns unwanted/expired medications to the pharmacy and the pharmacist countersigns the returns. There is a signing register for RNs and caregivers responsible for the administration of medication. RNs and caregivers receive annual competency assessments. There is a requirement for formal medication education annually. A weekly stocktake is completed on all controlled drugs kept in the safe. The local hospice nurses and specialists manage syringe drivers for palliative care residents. There is a locked drug trolley kept in a locked area when not in use. The medication fridge is checked weekly. Approved sharps containers are used for the safe disposal of sharps. There are no standing orders in use. There are no self-medicating residents. Eight medication charts sampled had photo identification and allergies/adverse reaction noted as applicable. Administration signing sheets are completed correctly for regular and prn medications. This is an improvement since the previous audit. This audit identified an improvement around the administration of controlled drugs. D16.5.e.i. 2, There is evidence of three monthly GP reviews of medications.

**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.

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> Administration signing sheets are completed correctly for regular and prn medications.
<b>Finding:</b> Two medication competent caregivers were not signing the controlled drugs signing administration form. This was corrected on the day of the audit.
<b>Corrective Action:</b> Ensure two medication competent persons to sign the controlled drugs signing administration form.
<b>Timeframe (days):</b> 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

<b>Attainment and Risk:</b> PA Low
<b>Evidence:</b> RNs and caregivers receive annual competency assessments.
<b>Finding:</b> There not been any formal medication education within the last two years. Since the draft report, the service advised that training on medicine management was held and has been undertaken by 18 caregivers
<b>Corrective Action:</b> Ensure medication competent persons receive formal medication education annually.
<b>Timeframe (days):</b> 90 (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.

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

**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.

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

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

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

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

**Attainment and Risk:** FA

**Evidence:**

There is a cook on duty from 8am to 2.30pm daily. A morning kitchen hand that prepares and serves breakfast and an afternoon kitchen hand from 4pm to 7.30pm to serve tea and the supper support the cook. The menu is a four-week rotation with the main meal at midday. There has been a dietitian review of the menu. Residents provide feedback and suggestions on the menu verbally and through the resident meetings. The manager has recently completed a review of individual breakfast requirements, which has resulted in an improvement in the delivery of breakfasts and hot buttered toast. Residents interviewed are very happy with the meals. The cook receives a resident dietary profile for each new admission and if there are changes to meal requirements. Likes and dislikes are known and alternatives offered. Diabetic residents receive alternatives to sweet desserts. Vegetarian and pureed diets are catered for. The cook is notified of any residents with weight loss and high calorie diet and smoothies are provided. The dining room is large and spacious. Meals are served directly from the Bain Marie. There is twice daily temperature monitoring of hot foods. Fridges and freezers are monitored daily. Chemicals are stored safely. D19.2 Staff have been trained in safe food handling, chemical safety (May 2013) and other relevant including in service on nutrition provided by the dietitian in September 2013. Since the partial provisional audit, the manager has completed a review of meal temperatures and delivery system of meals to rooms. The manager has with each resident personally to gain feedback on the meal temperatures when received by the resident in their rooms. The previous shortfall has been addressed.

#### 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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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.

<b>Attainment and Risk:</b> FA
<b>Evidence:</b>
<b>Finding:</b>
<b>Corrective Action:</b>
<b>Timeframe (days):</b> <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 has a current building warrant of fitness that expires 22 June 2014. There is a fire service letter of approval for fire evacuation scheme dated 28 April 2008. Six monthly fire drills occur with the most recent held September 2013. There is a reactive and planned maintenance system. Residents are observed moving freely about the home and accessing the communal areas with ease.

ARC D15.3; There is adequate equipment available for the rest home including a standing and lifting hoist, pressure area mattresses, hi-low beds, lifting belts, wheelchairs, mobility aids, chair scales and sensor mats.

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

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

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

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

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

**Attainment and Risk:** FA

**Evidence:**

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

**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

<b>Attainment and Risk:</b> FA
<b>Evidence:</b> There is an appropriate call bell system in all resident and communal areas with a corridor light that alerts staff as to their whereabouts. An effective communication system is in place between the registered nurse and caregiving team. The previous shortfall has been addressed.

**Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

An appropriate 'call system' is available to summon assistance when required.

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

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

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## 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:**

The policy around restraint and enablers is applicable to the type and size of the service (rest home and hospital).

The service has a restraint free philosophy.

Restraint is not used and there are currently no enablers used.

The policies and procedures are comprehensive, including definitions, processes and use of enablers.

The policy includes that enablers are voluntary and the least restrictive option.

Strategies are in place to minimise the use of restraint including mobility aids and supervision of residents.

Three caregivers and enrolled nurse interviewed confirm knowledge of restraint, enablers and management of challenging behaviours and all have completed a self-learning questionnaire/competency around management of restraint, enablers and challenging behaviour in 2013.

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

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

**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

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## 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:**

The surveillance programme is outlined in policy and is determined by the infection control committee.

An individual infection sheet is completed and the clinical nurse leader (infection control coordinator) confirms that this is used for individual clinical care. There is a monthly infection summary report completed in hard copy and data entered into an electronic database is then graphed and presented with a qualitative report to the quality and staff meetings. Staff interviewed including the three caregivers and an enrolled nurse state that the information is useful in enabling them to care for residents with infections better.

The surveillance of infection data assists in evaluating compliance with infection control practices and any changes lead to outcomes to improve service delivery.

### 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.

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