# M & K Atkins Limited

## Current Status: 8 November 2013

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

## General overview

Waratah Retirement Home provides residential care for up to 58 residents who require rest home care. Occupancy on the day of the audit was 57.The facility is owner operated. This unannounced surveillance audit has been undertaken to verify on-going compliance with specified parts of the Health and Disability Services Standard and the District Health Board aged care contract. The four areas identified as requiring improvement during the last audit have been effectively addressed.

Following this audit improvements are required in 22 areas. Issues rated low risk include open disclosure of events, access to complaints forms (this has been remedied during the audit), orientation of bureau staff, timely evaluation of care and treatment, documentation of treatment outcomes, timely medical review of problems and consistent three monthly medical reviews, individual activity plans, medication records, monitoring of food storage and served food temperatures, and records of enablers.

Issues rated moderate risk include timely updating of policies and procedures including those relating to infection control, document control, the risk management plan, corrective action following issues, statutory notifications, recording all adverse events, assessment of clinical problems after hours, documentation of short term and long term care plans, maintenance of clinical equipment, safety gates for external stairs (remedied during the audit), separation of clean and dirty linen collection, security of cleaning trolleys, storage cupboards, laundry, cleaning and external rubbish storage areas, monitoring of hot water temperatures in resident areas, safety of the hot water dispenser in the resident’s dining room, protocols for management of medical emergencies, removal of push button locks on resident’s bedroom doors (remedied during the audit), management of enablers and surveillance of infections.

There is one high risk area relating to safe management of hazardous chemicals.

Immediate improvement is required in relation to eight issues in medicine management that are reported in two partly attained areas. These together constitute a critical risk.

## Audit Summary as at 8 November 2013

Standards have been assessed and summarised below:

### Key

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

### Consumer Rights as at 8 November 2013

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| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of low risk. |

### Organisational Management as at 8 November 2013

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

### Continuum of Service Delivery as at 8 November 2013

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

### Safe and Appropriate Environment as at 8 November 2013

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| 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

### Restraint Minimisation and Safe Practice as at 8 November 2013

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

### Infection Prevention and Control as at 8 November 2013

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

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# HealthCERT Aged Residential Care Audit Report (version 3.91)

## Introduction

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

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

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

## Audit Report

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| --- | --- |
| **Legal entity name:** | M & K Atkins Ltd |
| **Certificate name:** | The Waratah Retirement Home |

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

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| --- | --- | --- | --- | --- |
| **Types of audit:** | Unannounced Surveillance Audit | | | |
| **Premises audited:** | 196 Henderson Valley Rd, Henderson, Auckland | | | |
| **Services audited:** | Rest Home Care | | | |
| **Dates of audit:** | **Start date:** | 8 November 2013 | **End date:** | 11 November 2013 |

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

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| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 57 |

## Audit Team

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXX | **Hours on site** | 16 | **Hours off site** | 8 |
| **Other Auditors** | XXXX | **Total hours on site** | 16 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXX |  |  | **Hours** | 3 |

## Sample Totals

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 32 | Total audit hours off site | 15 | Total audit hours | 47 |

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| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 5 | Number of staff interviewed | 9 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 6 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 15 | Total number of staff (headcount) | 32 | Number of relatives interviewed | 2 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## Declaration

I, XXXXX, Director of Auckland hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of 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:

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| --- | --- | --- |
| 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 Thursday, 28 November 2013

## Executive Summary of Audit

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| **General Overview** |
| Waratah Retirement Home provides residential care for up to 58 residents who require rest home care. Occupancy on the day of the audit was 57.The facility is owner operated. This unannounced surveillance audit has been undertaken to verify on-going compliance with specified parts of the Health and Disability Services Standard and the District Health Board aged care contract. The four areas identified as requiring improvement during the last audit have been effectively addressed.   Following this audit improvements are required in 22 areas. Issues rated low risk include open disclosure of events, access to complaints forms (this has been remedied during the audit), orientation of bureau staff, timely evaluation of care and treatment, documentation of treatment outcomes, timely medical review of problems and consistent three monthly medical reviews, individual activity plans, medication records, monitoring of food storage and served food temperatures, and records of enablers.  Issues rated moderate risk include timely updating of policies and procedures including those relating to infection control, document control, the risk management plan, corrective action following issues, statutory notifications, recording all adverse events, assessment of clinical problems after hours, documentation of short term and long term care plans, maintenance of clinical equipment, safety gates for external stairs (remedied during the audit), separation of clean and dirty linen collection, security of cleaning trolleys, storage cupboards, laundry, cleaning and external rubbish storage areas, monitoring of hot water temperatures in resident areas, safety of the hot water dispenser in the resident’s dining room, protocols for management of medical emergencies, removal of push button locks on resident’s bedroom doors (remedied during the audit), management of enablers and surveillance of infections.  There is one high risk area relating to safe management of hazardous chemicals.  Immediate improvement is required in relation to eight issues in medicine management that are reported in two partly attained areas. These together constitute a critical risk. |

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| Outcome 1.1: Consumer Rights |
| Open Disclosure procedures are in place to ensure service providers maintain open, transparent communication with residents and their families. Communications with family about adverse events and other matters are documented in residents progress notes. Improvement is required to ensure that open disclosure to residents and families includes any outbreak of infection in the facility. Interpreter services are arranged with family members, staff or Health Board services as needed. Resident interviews confirm very good communication between management, care staff, families, and residents. Interpreter services are available as needed.   The service has appropriate systems to manage complaints and a complaints register is maintained. Improvement is required to ensure that the complaints process, forms and a drop box are always available to residents and families. This has been addressed during the audit and now needs to be maintained. Since the last audit there has been one complaint investigated by the Health and Disabiity Commissioner that has been substantiated and resolved. There has also been one complaint investigated by the District Health Board that has been substantiated and is still being resolved. There have been no investigations by Ministry of Health, Police, ACC or Coroner since the previous audit at this facility. |

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| Outcome 1.2: Organisational Management |
| The facility mission, values and goals are included in the resident information booklet and staff orientation programme and reviewed annually. The service is managed by a non-clinical facility manager with more than 20 years’ experience in management of aged care with an experienced registered nurse managing clinical care. Both maintain relevant education and training.  There is a suitable quality management system in place. Improvement is required to ensure that documented policies, guidelines and practices are kept up to date, meet accepted good practice and comply with relevant standards. Improvement is also required to control of documents to ensure that the most current version is used by staff.   There is a documented risk management plan and process in place. Improvement is required to ensure that the plan addresses all areas of risk that may impact on service delivery, including management of clinical risk. Active risk management and health and safety processes have been maintained and quality improvement data is analysed and reviewed monthly.  Adverse events are recorded and investigated, resident and family informed and causes remedied promptly. Improvement is required to ensure that outbreaks of infection are included in records of adverse events and that records include details of actions taken to prevent recurrence including verification of effectiveness. Improvement is also required to ensure that requirements relating to essential notifications and statutory reporting are known and implemented.  Suitable employment processes are maintained and staffing is adequate in both numbers and skill mix to meet the needs of residents over the 24 hours. A registered nurse is on duty or on call 24 hours a day. Improvement is required to ensure that a suitable protocol is in place for assessment by a registered nurse or doctor of serious clinical matters that occur when there is no registered nurse on site.  All new staff employed since last audit have received an appropriate orientation. Improvement is required to ensure that bureau staff receive a suitable orientation prior to commencing their shift and that this is recorded.  The in-service education programme meets Aged Care Contract requirements. Practical competency in key processes and credentials of health care professionals are verified annually.  A previous improvement required in relation to Criterion 1.2.9.4 for identification of all pages in a resident’s file has been effectively addressed. |

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| Outcome 1.3: Continuum of Service Delivery |
| Resident’s receive timely and appropriate services in order to meet the assessed needs and desired outcome/goals. Each stage of service provision is undertaken by suitably qualified and/or experienced service providers. The Principal Nurse (PN) and the RNs have current annual practising certificates. Short and long term care plans are implemented. Improvement is required to ensure that these are sufficiently detailed and evaluated in a timely manner. The previous required improvement relating to dating of RN assessments has been effectively addressed. The GP admits a new resident within 24-48 hours. The GP is contacted when a resident manifests medical problems or when antibiotics are required. At least one of the two GPs visits the facility in a weekly basis. Improvement is required to ensure timely medical review of problems and consistent three monthly medical reviews.  The RNs use hand-over sheets from shift to shift and the contents are comprehensive. Progress notes are utilised to document wounds, challenging behaviour, infections and resident’s activity involvement. Improvement is required to ensure that all events are documented in the residents’ records, including outbreaks of infection, and that the residents response to treatment is recorded and evaluated.   The documented medication management policy is insufficiently detailed and does not meet all the requirements of current medicines regulations and guidelines. The requirements of the current policy are not implemented in practice. Improvements are required to ensure that all aspects of medication management meet current regulations and are implemented in practice. Improvement is required to ensure that staff who administer medications are verified as competent to do so.  A planned programme of various activities that reflect every day life is in place. Activity plans are generic. Improvement is required to ensure that they reflect the individual interests of the residents.  The food service menus have been reviewed by a dietitian. The cook and kitchen assistants follow good food handling practice when preparing meals. Improvement is required to ensure that all kitchen staff have current food handling certificates. A dietary requirement form is completed on admission and a list of special dietary requirements is on the kitchen notice board. Food procurement, transportation, delivery, and disposal comply with current legislation and guidelines. Opened foods in fridges are properly labelled and dated. Improvement is required to ensure that fridge and freezer temperatures are maintained within safe parameters. |

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| Outcome 1.4: Safe and Appropriate Environment |
| The building, facilities, and furnishings are well maintained and suitable for the care and support of elderly, dependent residents. Applicable building regulations and requirements are met. Improvement is required to ensure that lockable door handles are not installed on residents’ bedroom doors. These were disabled during the audit.  Suitable and sufficient equipment is provided to meet residents’ needs. There is a system in place to ensure the electrical safety of the environment, appliances and equipment. Improvement is required to ensure that all items of clinical equipment have regular functional checks and are calibrated where necessary. Improvement is required to ensure that hot water temperatures in resident areas are monitored and maintained within safe parameters. Improvement is also required to ensure that residents are protected from scalds from the boiling water zip in the dining room. Residents have access to an outdoor deck with safety balustrades. Improvement is required to protect residents from falls down the external steps and a safety gate has been installed during the audit.   A previous improvement required in relation to labelling of chemicals containers has been effectively addressed. Collection and disposal of waste are in accord with infection control principles and comply with local body requirements. Improvement is required to ensure that the laundry, cleaning and waste storage areas are secured from access by wandering residents, cleaning and sanitizing chemicals are securely and safely stored, that the cleaning trolleys are securely stored when unattended, and that clean linen is delivered and dirty linen collected using different trolleys.   Appropriate processes are in place to maintain the safety and security of residents during an environmental emergency. All staff attend fire safety training at least annually. Improvement is required to ensure that there are sufficient care staff with a current first aid certificate to provide one on each shift and that protocols are developed for management of relevant clinical emergencies. |

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| Outcome 2: Restraint Minimisation and Safe Practice |
| The Waratah Retirement Home demonstrates that the use of restraint is actively minimised. The previous requirement for improvement relating to Restraint Minimisation and Safe Restraint Practice Policy definitions of both restraint and an enabler has ben effectively addressed.There is a restraint register but it has not been updated. One resident uses an enabler but no restraint assessment has been completed. Enablers are included in the restraint minimisation policy. Improvement is required to ensure that staff know what constitutes an enabler. |

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| Outcome 3: Infection Prevention and Control |
| The Waratah Retirement Home has an infection control committee chaired by the administration officer. Infection surveillance is part of the monthly staff meeting. Infection control policies and procedures provided are out of date and do not comply with current best practice. Improvement is required to ensure that policies and procedures contain sufficient detail to provide clear guidelines for staff in maintaining infection control, in particular the containment and management of an outbreak of infection. The facility has purchased an up to date set of infection control guidelines. Improvement is required to ensure that staff receive relevant training and implement the policies in practice.   There is a suitable documented surveillance process that is appropriate to the size and complexity of the facility. Improvement is required to ensure that it is fully implemented, that all infections are included in the surveillance process, that treatment, duration and resolution are included in surveillance records, that surveillance data is further analysed to identify incidence and trends, and that surveillance information and outcomes are reported to staff together with specific recommendations to assist in achieving infection reduction and prevention. |

## Summary of Attainment

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 2 | 0 | 5 | 6 | 1 | 1 |
| **Criteria** | 0 | 18 | 0 | 7 | 12 | 2 | 1 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 35 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 61 |

## Corrective Action Requests (CAR) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.1.9: Communication | Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.1.9.1 | Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Open disclosure was not implemented in relation to the scabies outbreak earlier in 2013. Residents and families were not informed of the outbreak or of the measures being taken to manage and eliminate the infection. | Ensure that resident and families are informed when an outbreak of infection occurs and told of the measures being taken to manage and eliminate the infection, including regular updates of progress towards eliminating the infection. | 30 |
| HDS(C)S.2008 | Criterion 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. | PA Low | Information about the complaints process is not readily available to residents. It is in the residents hand book but not overtly displayed in the facility. Folders containing this information are not openly available in residents’ lounges as the facility policy requires. The information found in the dining room was in an unmarked folder and not known to staff. A drop box is not provided for anonymous complaints. These issues have been remedied during the audit. | Ensure that the processes implemented during the audit relating to display and availability of the complaints process, related information and forms are maintained. | 7 |
| HDS(C)S.2008 | Standard 1.2.3: Quality And Risk Management Systems | The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | Many documents in the policies and work procedures and resources manuals are undated or more than two years old or are inadequate, for example infection control policies. Health & Disability standards, Aged Care Contract requirements, best practice references and information sources are not identified. There is no requirement to ensure access to clinical expertise from the registered nurse or from external experts to inform the policy review process. Infection control policies and procedures provided in the staff resource room are out of date and do not comply with current best practice, for example the MRSA Guidelines 2000.  Policies and procedures do not contain sufficient detail to provide clear guidelines for staff in maintaining infection control, in particular the containment and management of an outbreak of infection. | Complete the full review of all policies and procedures, ensuring that current clinical advice and input is included in the process.  Ensure that relevant Health & Disability, Aged Care Contract requirements, best practice references and information sources are referenced in each document. Revise and update the infection control policies and guidelines provided to staff to comply with current best practice and provide clear guidelines for preventing and managing outbreaks of infection. Ensure that staff members receive education on the revised policies | 180 |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | The document control process has not been maintained and many policies and procedures provided for staff use to guide service delivery are out of date. | Develop and implement a document control system to ensure that resources, policies, procedures and external documents provided to staff to guide service delivery are maintained up to date. | 180 |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | The is no documented planning process in place to ensure that actions are taken to address areas needing improvement and monitored to ensure progress is made and improvements maintained, for example in response to the high incidence of falls; also a facility management plan had been developed to address and reverse the recent outbreak of scabies but it has not been implemented. | Develop and implement a process and records for planning and regularly reviewing progress on corrective and preventive actions to address areas requiring improvement, in particular adverse events. | 60 |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | The risk management plan does not include processes for identifying and managing clinical risks relevant to the service. | Expand the risk management process and plan to include all areas of risk that may impact on service delivery, including management of clinical risk. Develop and implement a defined clinical risk management process. | 30 |
| HDS(C)S.2008 | Standard 1.2.4: Adverse Event Reporting | All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.4.2 | The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Moderate | Responsibilities relating to essential notifications and statutory reporting requirements are not identified, known to staff, or implemented. For example the outbreak of scabies in June 2013 was not notified to the ‘Public Health Unit’ of the DHB. | Identify and document in a written policy the relevant essential notifications and statutory reporting requirements relating to the service, the persons responsible for making the notifications and the required timeframes. | 30 |
| HDS(C)S.2008 | Criterion 1.2.4.3 | The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Not all adverse events are addressed in the current process, for example the outbreak of scabies in June 2013 has not been recorded as an adverse event.  Records of six of six adverse events reviewed do not contain sufficient detail, for example –  1. Details of vital signs such as neurological observations after a fall in which a head injury might have occurred (actual head injury or an unwitnessed fall) not recorded the records. 2. Actions taken to prevent recurrence not documented in five of the six records. 3. Verification that actions taken to prevent a recurrence have been successful not documented in any of the six files. | Ensure that records of adverse events include – 1. Details of post –event assessments, in particular where a head injury may have occurred. 2. Actions taken to prevent recurrence. 3. Verification that actions taken to prevent a recurrence of the event have been successful | 30 |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | Bureau nurses are used occasionally. It is reported that they receive an orientation to the facility and emergency procedures, and to the care required by residents. These processes are not defined or recorded to ensure that the bureau staff understand their responsibilities prior to commencing the shift. | Develop and implement a documented, recorded process for orientating bureau staff to the facility, service delivery requirements and emergency procedures. | 90 |
| HDS(C)S.2008 | Standard 1.2.8: Service Provider Availability | Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Moderate | On call support for care staff is provided by the manager who lives on site. There are written guidelines for staff about the situations that require them to call the manager. These are all serious clinical situations. The manager makes the decision about whether or not to call for clinical advice from a registered nurse(RN) or doctor (GP). The manager is not a registered nurse (RN) and there are no protocols to guide the manager for referring serious clinical situations for RN or GP triage. | Develop and implement protocols for assessment of clinical situations after hours and referral to an RN or GP for triage. | 30 |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.3 | Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | Residents’ identified needs are not always documented in their files, for example, five incidents of scabies in May 2013 have not been documented in the individual residents’ files. 2. Actions taken to address the scabies infection have not been documented in individual short term care plans. | Ensure that all events that affect a resident are documented in their individual file, and a short term treatment plan developed where necessary to address the issue. | 30 |
| HDS(C)S.2008 | Standard 1.3.7: Planned Activities | 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. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | The activities coordinator utilises a generic activity plan for all residents which is not individualised and appropriate for all resident. | Ensure that activity plans are individualised, meaningful to the residents and reflect the resident’s preferred activities. | 90 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 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. | PA Low | 1. There is a care plan evaluation policy that meets the requirements of this standard but it is not implemented in practice.  2. Long term care plans are not evaluated every six months. One long term care plan has not been evaluated since 2009. Where an evaluation has been done there is insufficient documentation and evaluation of the interventions in place. 3. Two of two short term care plans do not indicate the degree of achievement or response to the intervention, nor progress towards meeting the desired outcome. | Ensure that- 1. Long term care plans are evaluated and reviewed at least every six months. 2. Care plan evaluations reflect the resident’s response to the interventions/treatment provided. | 90 |
| 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 Critical |  |  |  |
| 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 Critical | The documented medication management policy is insufficiently detailed and does not meet all the requirements of current medicines regulations in that there are no guidelines for managing PRN medications, supplements or other alternative therapies.  The requirements of the current policy are not implemented in practice. For example –  1. Six of 15 medication charts sighted have not been reviewed by the GP at least three monthly 2. The unlocked medication trolley is parked outside the nurse station and left unattended by the RN during medication rounds. 3. The medication cupboard is not locked when unattended. 4. The RN leaves the tablets with the resident and does not observe the resident swallowing the tablets. 5. The controlled drugs safe is locked inside a lockable cupboard but this cupboard is left unlocked when unattended. 6. There are expired medications inside the controlled drug safe, for example - oxynorm elixir, tramadol, zopiclone. Diasip liquid supplement, all noted to have expired in March 2013. 7. Medications are being crushed to assist administration without prior approval by the prescribing doctor or the pharmacist | Ensure that the medication management policy and medication management practices comply with current medicines legislation and guidelines. Provide evidence that all findings have been addressed. | 7 |
| 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 High | Refer to 1.3.12.1- RN not competent in giving the medications during the observed medication rounds. | Ensure RN competency | 7 |
| HDS(C)S.2008 | Criterion 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. | PA Low | Five of 15 medication charts reviewed do not have photos to identify the residents. 2. Prescriptions in six of 15 medication charts reviewed are either block signed or signed ditto (“) by the GP. Review dates do not include the year of review. | Ensure that medication management information and records comply with current legislation. | 30 |
| HDS(C)S.2008 | Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.5 | All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Moderate | There are five fridges and four freezers in the facility.  2. The temperatures of three fridges and the four freezers are not monitored.  3. The temperature of the upright fridge in the kitchen is monitored daily but is consistently recorded at temperatures below 2C.  4. On inspection the fridge smelt musty and needed to be cleaned. 5. There is no food temperature monitoring sighted. The cook confirms that temperature of served foods are not monitored. | 1. Identify the temperature ranges within which the fridges and freezers are to be kept.  2. Implement and record daily monitoring of all fridges and freezers. 3. Define the process to be followed when the temperatures fall outside the required parameters. 4. It is noted that the upright fridge has been cleaned during the audit. Implement a monitoring process to ensure that this is maintained. 5. Ensure that food temperature is monitored and recorded. | 30 |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA High |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Moderate | The equipment maintenance system does not include all items of clinical equipment. For example there are no processes in place for - 1. Regular functional or electrical checks of the sling hoist or for regular cleaning of the hoist or the slings. 2. Regular calibration of the digital thermometer and the digital sphygmomanometer. | Implement a regime for regular functional checks and cleaning of the hoists and regular calibration of the digital thermometer and the digital sphygmomanometer. | 30 |
| HDS(C)S.2008 | Criterion 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. | PA High | The indoor physical environment is not consistently safe for all residents. For example –  1. The doors to the laundry / cleaning area and to the external cleaning /rubbish storage area are not secured when the areas are unattended by staff.  2. Some bedrooms have doors with a push button door handle lock which some residents may not be able to manipulate when they want to get out. The locks are to prevent unauthorised access by confused residents into other resident’s bedrooms but may also prevent residents from exiting their rooms as they wish, resulting in a restraint situation. There is no evidence that residents have consented to this arrangement. 3. Store cupboards are not secured from unwanted access, including the switchboard cupboard. The space in one unused bathroom used to store unused equipment is poorly structured for storage and equipment could tip and fall on those entering (visitors and residents). 4. The same trolley is used to collect dirty linen and deliver clean linen at the same time.  5. A boiling water Zip is installed in a tea bay in the residents’ dining room for use of residents and visitors. There is no means of protecting users from scalds when getting hot water from the Zip and access is open to anyone entering the room. 6. The system for monitoring the temperatures of hot water in resident areas has not been maintained.  Hazardous chemicals are not all safely stored. For example –  1. Clear plastic pump bottles of hand sanitizer for use by staff are placed on hand rails in corridors throughout the facility where they are openly accessible by residents and could be mistaken for drinking bottles. 2. Containers of cleaning chemicals are stacked on top of each other on the floor of the cleaning cupboard, including a container labelled inflammable liquid. 3. Bottles of cleaning fluids are stored on the window sill in the laundry that is openly accessible to residents. These were removed to a cupboard during the audit.  4. The cleaning trolley is put away in an unused, unsecured toilet when not in use. Bottles of diluted Dettol that looks like milk are left on the cleaning trolley and are readily accessible to residents.  There are insufficient processes in place for management of clinical emergencies, for example:  1. There are no documented protocols in place for response to clinical emergencies apart from CPR procedures. 2. Not every shift has a staff member with a current first aid certificate rostered on duty. | Corrective Action: A - Physical environment: 1. Install mechanisms on the doors to the laundry / cleaning area and to the external cleaning /rubbish storage area to prevent access by residents when the areas are unoccupied. 2. Remove locking door handles from resident’s bedrooms. This has been actioned during the audit. 3. Secure storerooms from unwanted access. Ensure that storage areas are appropriately fitted to prevent stored items from falling over. 4. Use separate trolleys for delivering clean linen and for removing dirty linen. 5. Provide mechanisms to ensure that residents and visitors are protected from scalds when getting boiling water from the Zip in the dining room. 6. Consistently maintain the system for monitoring the temperatures of hot water in resident areas.  B - Hazardous chemicals: 1. Remove the pump bottles of hand sanitizer from the corridors and install suitable fixed dispensers to prevent access by residents or visitors who may drink the fluid. 2. Rearrange the chemicals storage cupboard to eliminate the need to stack containers on top of each other. Store inflammable liquids away from cleaning solutions. 3. Containers of cleaning fluid on the laundry windowsill have been removed to a secure cupboard. Maintain secure storage of chemicals in the laundry. 4. Store the cleaning trolley in a secure area.  C - Clinical Emergency Processes: 1. Develop protocols for management of clinical emergencies. 2. Ensure that sufficient care staff have a current first aid certificate to provide at least one on every shift. | 30 |
| HDS(C)S.2008 | Criterion 1.4.2.6 | Consumers are provided with safe and accessible external areas that meet their needs. | PA Moderate | There is no means of preventing residents from falling down a steep set of stairs leading down from the deck to the garden. | To protect residents from falls down the external steps a safety gate has been installed during the audit. No further action is necessary. | 30 |
| HDS(RMSP)S.2008 | Standard 2.1.1: Restraint minimisation | Services demonstrate that the use of restraint is actively minimised. | PA Low |  |  |  |
| HDS(RMSP)S.2008 | Criterion 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. | PA Low | 1. A restraint assessment has been completed for the resident using the bed pole as an enabler.  2. The restraint register and record do not include the resident with the enabler.  3. Staff are not aware what is an enabler, for example the “bed pole” used by the resident | 1. Ensure that a restraint assessment, evaluation and risk management plan is completed for the resident.   2. Ensure that enablers are entered in the restraint register.  3. Provide further education for staff about use of enablers.(Refer to 1.2.7.5) | 90 |
| HDS(IPC)S.2008 | Standard 3.5: Surveillance | Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Moderate |  |  |  |
| HDS(IPC)S.2008 | Criterion 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. | PA Moderate | There is a suitable documented surveillance process in place but it has not been implemented.   1. Not all infections are included in the surveillance process, for example five cases of scabies infection reported in May 2013 have not been recorded in the surveillance process.  2. Treatment, duration and resolution are not included in the surveillance process and record.   3. Surveillance data is not further analysed to identify incidence and trends.  4. There is no evidence that surveillance information and outcomes are reported to staff. | Fully implement the documented surveillance process to ensure that -  1. All infections are included in the surveillance process.  2. Treatment, duration and resolution are included in the surveillance record.   3. Surveillance data is further analysed to identify incidence and trends.  4. Surveillance information and outcomes are reported to staff. | 30 |

## Continuous Improvement (CI) Report

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# 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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Open Disclosure procedures are in place to ensure service providers maintain open, transparent communication with residents and their families. Communications with family about adverse events are documented in residents progress notes. The five residents interviewed had not been informed of the presence of scabies in the facility. Improvement is required to ensure that open disclosure to residents and families includes any outbreak of infection in the facility. Interpreter services are arranged with family members, staff or Health Board services as needed. Resident interviews confirm very good communication between management, care staff, families, and residents. Interpreter services are available as needed. Relevant ARC requirements are met. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Review of the records of five residents who contracted scabies earlier in the year and interviews with relatives, the facility manager and clinical manager indicate that the residents and families were not informed about the outbreak of the infection or the measures taken to combat it. |
| **Finding:** |
| Open disclosure was not implemented in relation to the scabies outbreak earlier in 2013. Residents and families were not informed of the outbreak or of the measures being taken to manage and eliminate the infection. |
| **Corrective Action:** |
| Ensure that resident and families are informed when an outbreak of infection occurs and told of the measures being taken to manage and eliminate the infection, including regular updates of progress towards eliminating the infection. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
| The service has appropriate systems to manage complaints and a complaints register is maintained. Information about the Code, advocacy services and the compaints process is included in the resident handbook. Inspection indicates that the information is not obviously available in the facility. Improvement is required to ensure that the complaints process, forms and a drop box are always readily available to residents and families. Since the last audit there has been one complaint investigated by the Health and Disabiity Commissioner that has been substantiated and resolved. There has also been one complaint investigated by the District Health Board that has been substantiated and is still being resolved. There have been no investigations by Ministry of Health, Police, ACC or Coroner since the previous audit at this facility. |

##### 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The complaints process is included in the resident information pack and placed with complaints forms in folders in the two lounges and the dining room. On inspection these were not easy to find. There is no drop box for written complaints. During the audit the complaints process, forms and a drop box have been installed at the front entrance during the audit. The folders containing the complaints information have been clearly labelled and placed in prominent positions in the lounges and dining room. Interviews with five residents and two relatives indicate that they are happy with the response to any concerns they raise and are aware of the complaints process and how to make a formal complaint should they wish to do so. |
| **Finding:** |
| Information about the complaints process is not readily available to residents. It is in the residents hand book but not overtly displayed in the facility. Folders containing this information are not openly available in residents’ lounges as the facility policy requires. The information found in the dining room was in an unmarked folder and not known to staff. A drop box is not provided for anonymous complaints. These issues have been remedied during the audit. |
| **Corrective Action:** |
| Ensure that the processes implemented during the audit relating to display and availability of the complaints process, related information and forms are maintained. |
| **Timeframe (days):** 7 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility mission, values and goals are included in the resident information booklet and staff orientation programme and reviewed annually. The service is managed by a non-clinical facility manager with more than 20 years’ experience in management of aged care. The facility manager’s position description clearly outlines the responsibilities and authorities of the role. The facility manager is assisted by an experienced registered nurse who manages clinical care. Both have evidence of relevant continuing education of at least eight hours annually. Relevant ARC requirements are met. |

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is a suitable quality management system in place that is coordinated by the administration manager and monitored by the facility manager and the PN. Minutes of quality tram meetings and staff meetings indicate that quality data relating to adverse events, complaints, infection control, health and safety and systems and supplies is collected and reviewed by the facility manager, admin manager and principle nurse monthly. Quality matters are included in the orientation of new staff and discussed at monthly quality meetings and displayed on the staff notice board. Internal quality audits are used to monitor compliance with the quality system.  Improvement is required to ensure that documented policies, guidelines and practices are kept up to date, meet accepted good practice and comply with relevant standards. Improvement is also required to control of documents to ensure that the most current version is used by staff. A previous improvement required in relation to Criterion 1.2.9.4- identification of all pages in a resident’s file, has been effectively addressed.  There is a documented risk management plan and process in place. Improvement is required to ensure that the plan addresses all areas of risk that may impact on service delivery, including management of clinical risk. Active risk management and health and safety processes have been maintained and quality improvement data is analysed and reviewed monthly.  ARC requirements D1.1, D17.7a, D17.7e, D19.2, D19.3a are not met. All other relevant ARC requirements are met. |

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| A collection of policies, procedures and guidelines is available that addresses all areas of service delivery. On review, many of the documents are out of date and lack sufficient detail to provide good guidelines for staff in providing best practice care to residents. The recently appointed administration manager is currently undertaking a full review and update of all policies and procedures with assistance from an external adviser but there is no requirement to include the registered nurse in the process.   Infection control policies and procedures provided in the staff resource room are out of date and do not comply with current best practice, for example the MRSA Guidelines 2000. Policies and procedures do not contain sufficient detail to provide clear guidelines for staff in maintaining infection control, in particular the containment and management of an outbreak of infection. It is acknowledged that the latest version of the Bug Control Manual has just been obtained, and that advice is being received from a DHB nurse advisor. |
| **Finding:** |
| Many documents in the policies and work procedures and resources manuals are undated or more than two years old or are inadequate, for example infection control policies. Health & Disability standards, Aged Care Contract requirements, best practice references and information sources are not identified. There is no requirement to ensure access to clinical expertise from the registered nurse or from external experts to inform the policy review process. Infection control policies and procedures provided in the staff resource room are out of date and do not comply with current best practice, for example the MRSA Guidelines 2000.  Policies and procedures do not contain sufficient detail to provide clear guidelines for staff in maintaining infection control, in particular the containment and management of an outbreak of infection. |
| **Corrective Action:** |
| Complete the full review of all policies and procedures, ensuring that current clinical advice and input is included in the process.  Ensure that relevant Health & Disability, Aged Care Contract requirements, best practice references and information sources are referenced in each document. Revise and update the infection control policies and guidelines provided to staff to comply with current best practice and provide clear guidelines for preventing and managing outbreaks of infection. Ensure that staff members receive education on the revised policies |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Policy and procedure documents are clearly titled, dated and authorised by the facility manager. Policy and procedure folders sighted in the nurses’ station for use of staff contain many out of date documents. The document control system previously used to ensure the integrity of the document control process has lapsed over the last twelve months and the recently appointed administration manager is currently working to restore it and ensure that staff have up to date documents to work with. |
| **Finding:** |
| The document control process has not been maintained and many policies and procedures provided for staff use to guide service delivery are out of date. |
| **Corrective Action:** |
| Develop and implement a document control system to ensure that resources, policies, procedures and external documents provided to staff to guide service delivery are maintained up to date. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Review of adverse event reports, complaint records and management interviews indicate that issues and problems are addressed but the process is ad hoc and some issue have slipped through the system. There is no defined planning process in place to ensure that actions are taken to address areas needing improvement and monitored to ensure progress is made and improvements maintained, for example in response to the high incidence of falls. A facility management plan had been developed to address and reverse the outbreak of scabies but staff interviews and resident records indicate that it has not been implemented. |
| **Finding:** |
| The is no documented planning process in place to ensure that actions are taken to address areas needing improvement and monitored to ensure progress is made and improvements maintained, for example in response to the high incidence of falls; also a facility management plan had been developed to address and reverse the recent outbreak of scabies but it has not been implemented. |
| **Corrective Action:** |
| Develop and implement a process and records for planning and regularly reviewing progress on corrective and preventive actions to address areas requiring improvement, in particular adverse events. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:  
(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;  
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| There is a documented risk management plan and process in place. The plan addresses health and safety risks and some system and supply risks but does not include all areas of clinical risk that may impact on service delivery. Management interview indicates that clinical risk is managed as required by the PN and the facility manager but there is no defined clinical risk management process. Review of records confirms that active hazard management and health and safety processes have been maintained. Minutes of management and staff meetings and associated reports confirm that health and safety data is analysed and reviewed monthly. |
| **Finding:** |
| The risk management plan does not include processes for identifying and managing clinical risks relevant to the service. |
| **Corrective Action:** |
| Expand the risk management process and plan to include all areas of risk that may impact on service delivery, including management of clinical risk. Develop and implement a defined clinical risk management process. |
| **Timeframe (days):** 30 *(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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Adverse events are recorded and investigated and resident and family informed. Improvement is required to ensure outbreaks of infection are included in records of adverse events and that records include details of actions taken in response to the event and to prevent recurrence, and verification that the actions have been effective. Improvement is also required to ensure that requirements relating to essential notifications and statutory reporting are known and implemented. |

##### 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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The manager is aware of reporting requirements in relation to accidents, deaths, security events and disruption to services. Requirements for essential notification of public health matters, for example infectious outbreaks are not understood. |
| **Finding:** |
| Responsibilities relating to essential notifications and statutory reporting requirements are not identified, known to staff, or implemented. For example the outbreak of scabies in June 2013 was not notified to the ‘Public Health Unit’ of the DHB. |
| **Corrective Action:** |
| Identify and document in a written policy the relevant essential notifications and statutory reporting requirements relating to the service, the persons responsible for making the notifications and the required timeframes. |
| **Timeframe (days):** 30 *(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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Adverse events are documented and the records retained in a register with copies in resident files. Adverse events recorded include accidents, incidents, medication errors and omissions, system and supply problems. Records of six adverse events were reviewed and indicate that records do not consistently contain sufficient detail to verify that actions taken after an adverse event are appropriate, for example - details of vital signs such as neurological observations after a fall in which a head injury might have occurred (actual head injury or an unwitnessed fall) have not been recorded, actions taken to prevent recurrence have not been documented in five of the six records and verification that actions taken to prevent a recurrence have been successful have not been documented in any of the six files. Five cases of scabies that have occurred during the outbreak in June 2013 have not been recorded as adverse events, nor has the outbreak itself been documented as an adverse event. |
| **Finding:** |
| Not all adverse events are addressed in the current process, for example the outbreak of scabies in June 2013 has not been recorded as an adverse event.  Records of six of six adverse events reviewed do not contain sufficient detail, for example –  1. Details of vital signs such as neurological observations after a fall in which a head injury might have occurred (actual head injury or an unwitnessed fall) not recorded the records. 2. Actions taken to prevent recurrence not documented in five of the six records. 3. Verification that actions taken to prevent a recurrence have been successful not documented in any of the six files. |
| **Corrective Action:** |
| Ensure that records of adverse events include – 1. Details of post –event assessments, in particular where a head injury may have occurred. 2. Actions taken to prevent recurrence. 3. Verification that actions taken to prevent a recurrence of the event have been successful |
| **Timeframe (days):** 30 *(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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Review of personnel records indicates that all new staff employed since last audit have received an appropriate orientation. Management and staff interviews indicate that bureau staff receive a suitable orientation prior to commencing their shift but this is not documented and records are not maintained. An education plan and staff training records indicate that a planned programme of relevant education is implemented. The in-service education programme meets Aged Care Contract requirements. Personnel records reviewed and staff interview indicate that practical competency in key processes and credentials of health care professionals are verified annually. Improvement is required to ensure that adherence to medication policy regarding administration processes is consistently maintained. (refer corrective action under 1.3.12.1) ARC requirements relating to 17.6b are not met. All other relevant ARC requirements are met. |

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

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

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

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Review of personnel records of staff employed since the last audit and interviews with staff indicate that all staff receive a suitable orientation to the facility and to the tasks of their position. The documented orientation programme covers the elements required by the ARC contract. Review of rosters indicates that bureau nurses are used occasionally. It is reported that they receive an orientation to the facility and emergency procedures, and to the care required by residents. This process is not defined or recorded to ensure that the bureau staff understand their responsibilities prior to commencing the shift. |
| **Finding:** |
| Bureau nurses are used occasionally. It is reported that they receive an orientation to the facility and emergency procedures, and to the care required by residents. These processes are not defined or recorded to ensure that the bureau staff understand their responsibilities prior to commencing the shift. |
| **Corrective Action:** |
| Develop and implement a documented, recorded process for orientating bureau staff to the facility, service delivery requirements and emergency procedures. |
| **Timeframe (days):** 90 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
| (Refer to 2.1.1.4) |
| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The documented staffing policies, review of rosters over the last six months, and interviews with six staff and five residents indicate that suitable employment processes are maintained and staffing is adequate in both numbers and skill mix to meet the needs of residents over the 24 hours. A registered nurse is on duty or on call 24 hours a day. Improvement is required to ensure that serious clinical situations occurring after hours are referred to an RN or GP for assessment. |

##### 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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Staff report that on call support for care staff is provided by the manager who lives on site. There are written guidelines for staff about the situations that require them to call the manager. These are all serious clinical situations. The manager makes the decision about whether or not to call for clinical advice from a registered nurse(RN) or doctor (GP). The manager is not a registered nurse (RN) and there is no protocol for referring serious clinical situations for RN or GP triage. |
| **Finding:** |
| On call support for care staff is provided by the manager who lives on site. There are written guidelines for staff about the situations that require them to call the manager. These are all serious clinical situations. The manager makes the decision about whether or not to call for clinical advice from a registered nurse(RN) or doctor (GP). The manager is not a registered nurse (RN) and there are no protocols to guide the manager for referring serious clinical situations for RN or GP triage. |
| **Corrective Action:** |
| Develop and implement protocols for assessment of clinical situations after hours and referral to an RN or GP for triage. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Outcome 1.3: Continuum of Service Delivery

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

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The Principal Nurse (PN) and the registered nurse RNs have current annual practising certificates as sighted. Long term care plans are created and implemented within three weeks after admission. Improvement is required to ensure that they are evaluated every six months. Short term care plans are implemented but no evaluation nor response to the treatment is documented. The PN reports that the short term problem is resolved but is not documented in the progress notes. Improvement is required to ensure that the resident’s response to treatment is documented in short term care plans.  On admission, the PN or admitting RN complete an admission assessment which includes nutrition, skin, elimination, falls risk, mobility, orientation, eating, drinking, values and social history. The activities coordinator ensures that the activities are attended by the residents and a monthly attendance sheet is sighted in the activities folder. An activities initial interview form is in place and utilised by the activities coordinator which also includes cultural assessment. The PN or RNs notify the GP when a new resident is admitted to the facility and ensure that the GP admits the new resident within 24-48 hours. The GP is also contacted by the PN when a resident manifests medical problems that require immediate attention or when antibiotics are required. At least one of the two GPs visits the facility in a weekly basis.  The RNs use hand-over sheets. The contents of the hand-over are comprehensive. They use the progress notes to document the residents' current status including wound, challenging behaviour, infections and resident’s activity involvement. The RN, physiotherapist, podiatrist, occupational therapist and other allied health team write in the progress notes which is integrated in the resident’s file but the activities coordinator has a separate folder for the activities assessments and monthly attendance sheets.  The principal nurse (PN) and registered nurses (RNs) create the long term care plans however these are not evaluated every six months. Care plans are in place and sighted but are insufficiently detailed. Short term care plans sighted have no evaluations and response to treatment is not documented.  The activities coordinator reports that each resident’s activity involvement is reviewed every six months. Activity plans are generic and do not reflect the individual interests of the residents.  Tracer Methodology:   XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  ARC requirements D16.5c1, D16.5cii are not met. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| All residents are assessed on admission by the RN. The previous requirement relating to RN assessment dates is now fully attained and implemented.  The GP reviews new residents on admission or within two days and at least three monthly thereafter. Services are not consistently provided within time frames that safely meet the needs of the resident. Review of five resident records indicates that long term care plans and activity plans are created and implemented within three weeks from admission, however the care plans are not evaluated at least six monthly. Short term care plans are in place upon identification of an acute problem like infection but there is no documentation or evaluation of resident’s response to the treatment. Improvement is required to ensure that progress notes reflect the resident’s response to the management plan and completion of the treatment regimen.  Tracer Methodology in 1.3.3. XXXXXX *This information has been deleted as it is specific to the health care of a resident.* |
| **Finding:** |
| 1. Residents’ identified needs are not always documented in their files, for example, five incidents of scabies in May 2013 have not been documented in the individual residents’ files. 2. Actions taken to address the scabies infection have not been documented in individual short term care plans. |
| **Corrective Action:** |
| Ensure that all events that affect a resident are documented in their individual file, and a short term treatment plan developed where necessary to address the issue. |
| **Timeframe (days):** 30 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The care plans document the individual resident’s assessed needs, interventions and goals. All five of five resident files reviewed indicate desired outcomes related to the problems identified in the admission assessment. Short term care plan interventions are appropriate to meet the desired outcome. The PN seeks specialist advise from the GNS or infection control nurse from the district health board when necessary. Residents interviewed during the audit confirm services are adequate to meet their needs and expected outcomes.  ARC requirements are met. |

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

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

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

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The activities coordinator is new to the role, has not yet attended relevant training and creates a yearly activities planner as sighted. Weekly activity plans are posted around the facility and include physical stimulation, mental stimulation, spiritual, social/recreation and previous roles. The activities coordinator utilises both group and one-on-one approach in facilitating activities for the residents. Library service comes two times per month. A monthly attendance sheet of activity participation is sighted and activities are appropriate for the residents. Each resident’s involvement in activities is evaluated every six months  The activities coordinator utilises a generic activity plan for all residents. Improvement is required to ensure that the activity plan is individualised and reflects individual interests. ARC requirement D16.5ciii is not met. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The activities coordinator is new for the role, has not attended relevant trainings and creates a yearly activities planner as sighted. Methodist and Catholic priests visit the facility every two weeks. Weekly activity plans are posed around the facility. Each resident’s involvement in activities evaluated every six months which include physical stimulation (exercise, walks, physical games, sit dancing), mental stimulation (housie, table games, quizzes, newspaper reading), social/recreation (outings, entertainment, music, art) and previous roles (baking, gardening, flower arranging). Monthly attendance sheet of activity participation is sighted and activities are appropriate for the residents. The activities coordinator utilises a generic activity plan for all resident which is not individualised and appropriate for all resident. Monthly attendance sheet of activity participation is sighted and activities are appropriate for the residents. The activities coordinator utilises both group and one-on-one approach in facilitating activities for the residents. Library service comes two times per month. The activities coordinator utilise a generic activity plan for all resident which is not individualised and appropriate for all resident. |
| **Finding:** |
| The activities coordinator utilises a generic activity plan for all residents which is not individualised and appropriate for all resident. |
| **Corrective Action:** |
| Ensure that activity plans are individualised, meaningful to the residents and reflect the resident’s preferred activities. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Two of two short term care plans are comprehensive but no evidence of evaluation is sighted. There is no resolution of the problem documented in the progress notes. It is resident-focused but do not indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. One resident long term care plan was last evaluated on 2009. Short term care plans are created by the PN or RN’s and evaluated in a timely manner as sighted in the progress notes. Activity involvement of each resident is evaluated every six months as sighted in the activities folder.   ARC requirements are not met. |

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

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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a care plan evaluation policy that meets the requirements of this standard but it is not implemented in practice. Review of five residents’ files indicates that activity involvement of each resident is evaluated every six months as sighted in the activities folder. Long term care plans are not evaluated every six months. One long term care plan has not been evaluated since 2009. Where an evaluation has been done there is insufficient documentation and evaluation of the interventions in place. Two of two short term care plans do not indicate the degree of achievement or response to the intervention, nor progress towards meeting the desired outcome. There is evidence in residents’ progress notes and care plans that changes are made to care and treatments in response to the changing needs of the resident. |
| **Finding:** |
| 1. There is a care plan evaluation policy that meets the requirements of this standard but it is not implemented in practice.  2. Long term care plans are not evaluated every six months. One long term care plan has not been evaluated since 2009. Where an evaluation has been done there is insufficient documentation and evaluation of the interventions in place. 3. Two of two short term care plans do not indicate the degree of achievement or response to the intervention, nor progress towards meeting the desired outcome. |
| **Corrective Action:** |
| Ensure that- 1. Long term care plans are evaluated and reviewed at least every six months. 2. Care plan evaluations reflect the resident’s response to the interventions/treatment provided. |
| **Timeframe (days):** 90 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):** 90 *(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

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| **Attainment and Risk:** PA Critical |
| **Evidence:** |
| A documented medication management policy and system is in place that is suitable for a non-acute aged care facility. Improvement is required to ensure that the policy addresses all the areas required by medicines regulations, in particular management of PRN medications, supplements and alternative therapies. Fifteen of 15 medication charts reviewed demonstrate dates, signatures and legibility. Allergy / sensitivity status is noted. Discontinued medications are dated/signed and legible. Medical review dates do not include the year of review. A lockable medication trolley and cupboard are provided for storage of medications.  Improvement is required to ensure that they are secured when unattended.   Medicines are only prescribed by the general practitioners (GP). Prescriptions in six of 15 medication charts reviewed are either block signed or signed ditto (“) by the GP. Five of 15 medication charts have no photos to identify the resident. Medicine review dates do not have the year of review i.e. only the day and month. All medicines are dispensed by the pharmacy in color-coded medico blister packs. The new cycle of medications is checked by two RNs on receipt. The pharmacy is available for advice and support when needed.  The controlled drugs safe is locked inside a lockable cupboard in the PN office. The pharmacy staff and the RN enter the delivered controlled drugs into the controlled drugs register on delivery. Regular weekly stocktake is conducted and documented by two RNs. The controlled drugs registers are sighted and correct.  The PN reports that unwanted or expired regular medications are given to visiting pharmacy staff. Improvement is required to ensure that expired stock sighted in the drug safe is returned to the pharmacy. A secure sharps bin is sighted inside the nurses’ station. The temperature of the medication fridge containing insulin vials is monitored and maintained within 2-8C.  The six staff who administer medications have current medication competency records. Observation of the midday medication round identifies that the RN does not consistently follow documented medication administration procedure. Improvement is required to ensure that the documented policy forbidding crushing of medications is adhered to unless the doctor prescribes otherwise, and that the RN waits to ensure that the resident has swallowed the tablets before leaving. There is a policy and procedure in place to ensure that residents who wish to self-administer can do safely. Currently one resident self-administers medications. Review of the resident’s file indicates that the self-medicating assessment tool has been completed and signed, and the medications have been reviewed by the GP every three months. Observation confirms that the resident locks the medications in a drawer inside the room. The staff ensure that the resident takes the prescribed medications.  ARC requirements D1.1g; D15.3c; D16.5e.i.2; D19.2d are not met. |

##### 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.

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| **Attainment and Risk:** PA Critical |
| **Evidence:** |
| Six of 15 medication charts sighted have not been reviewed by the GP at least three monthly. Review of the medication records of the tracer resident indicate that a medication review occurred on 13 June 2013, with one page missing where the scabies medication is said to have been written by the GP.  During audit, both the medication cupboard and the medication trolley are observed to be left unsecured when unattended. Expired medications are observed inside the controlled drug safe.  During the medication round the RN was observed to leave tablets with a resident and not ensure that they had been swallowed. The medication policy forbids crushing of medications yet some medications for one resident are crushed and administered in fruit puree without documented approval from the GP. There are sticky notes on the medication sheet and one sticky note is “Do not crush Felodipine, Thyroxine and Diuride”. The PN reports that all of the resident’s medications are crushed except the three medications written on the sticky note. The PN reports that they contact the pharmacy to ask what medications can be crushed. The GP has not documented instructions in the progress notes allowing the staff to crush the resident’s medications. |
| **Finding:** |
| The documented medication management policy is insufficiently detailed and does not meet all the requirements of current medicines regulations in that there are no guidelines for managing PRN medications, supplements or other alternative therapies.  The requirements of the current policy are not implemented in practice. For example –  1. Six of 15 medication charts sighted have not been reviewed by the GP at least three monthly 2. The unlocked medication trolley is parked outside the nurse station and left unattended by the RN during medication rounds. 3. The medication cupboard is not locked when unattended. 4. The RN leaves the tablets with the resident and does not observe the resident swallowing the tablets. 5. The controlled drugs safe is locked inside a lockable cupboard but this cupboard is left unlocked when unattended. 6. There are expired medications inside the controlled drug safe noted to have expired in March 2013. 7. Medications are being crushed to assist administration without prior approval by the prescribing doctor or the pharmacist |
| **Corrective Action:** |
| Ensure that the medication management policy and medication management practices comply with current medicines legislation and guidelines. Provide evidence that all findings have been addressed. |
| **Timeframe (days):** 7 *(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.

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| **Attainment and Risk:** PA High |
| **Evidence:** |
| Refer to 1.3.12.1- RN not competent in giving the medications during the observed medication rounds. |
| **Finding:** |
| Refer to 1.3.12.1- RN not competent in giving the medications during the observed medication rounds. |
| **Corrective Action:** |
| Ensure RN competency |
| **Timeframe (days):** 7 *(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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Prescriptions in six of 15 medication charts reviewed are either block signed or signed ditto (“) by the GP. Five of 15 medication charts have no photos to identify the resident. Medicine review dates do not have the year of review i.e. only the day and month. |
| **Finding:** |
| 1. Five of 15 medication charts reviewed do not have photos to identify the residents. 2. Prescriptions in six of 15 medication charts reviewed are either block signed or signed ditto (“) by the GP. Review dates do not include the year of review. |
| **Corrective Action:** |
| Ensure that medication management information and records comply with current legislation. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The summer and winter menus have been reviewed by the dietitian in August 2011. Meals are served at times that reflect community norms. Policies in food service are implemented. The cook and kitchen assistants prepare meals wearing disposable hats and kitchen gloves. The PN or RNs inform the cook when a new resident is admitted. A list of special dietary requirements like diabetic or puree diets is created and updated by the cook regularly as sighted on the kitchen board. The cook confirms that she provides modified meals like diabetic or puree diets. Dietary requirement form is completed on admission and kept in the resident’s file. Residents are weighed monthly as verified in the residents file. Five of five residents reviewed have stable weights. Resident’s verbalise that they enjoy the meals served in the facility. Observation of the lunch meal indicates the food is attractively presented.  Food procurement, transportation, delivery, and disposal comply with current legislation, and guidelines. There are five fridges and four freezers in the facility. The temperatures of three fridges and the four freezers are not monitored. The temperature of the upright fridge in the kitchen is monitored daily but is consistently recorded at temperatures below 2C. On inspection, the fridge smelt musty and needed to be cleaned. There is no food temperature monitoring sighted. The cook reports that they do not check the temperature of the meals served for the residents. The cook rotates the canned goods upon delivery. A first in-first out system is in place as verified during the interview with the cook. The cook places orders to the suppliers on a weekly basis. The staff members are observed preparing meals for lunch and they are all wearing disposable hats and use clean technique in food preparation. Opened foods are properly labelled and dated inside the chiller. The cook reported that they have enough equipment to prepare the meals for the residents. Four of five staff members working in the kitchen have food handling certificates. The staff member without food handling certificate is booked for training as sighted.  ARC requirement D1.1a is not met. |

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

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

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Food procurement, transportation, delivery, and disposal comply with current legislation and guidelines. There are five fridges and four freezers in the facility. The temperatures of three fridges and the four freezers are not monitored. The temperature of the upright fridge in the kitchen is monitored daily but is consistently recorded at temperatures below 2C. On inspection, the fridge smelt musty and needed to be cleaned. There is no food temperature monitoring sighted. The cook reports that they do not check the temperature of the meals served for the residents. |
| **Finding:** |
| There are five fridges and four freezers in the facility.  2. The temperatures of three fridges and the four freezers are not monitored.  3. The temperature of the upright fridge in the kitchen is monitored daily but is consistently recorded at temperatures below 2C.  4. On inspection the fridge smelt musty and needed to be cleaned. 5. There is no food temperature monitoring sighted. The cook confirms that temperature of served foods are not monitored. |
| **Corrective Action:** |
| 1. Identify the temperature ranges within which the fridges and freezers are to be kept.  2. Implement and record daily monitoring of all fridges and freezers. 3. Define the process to be followed when the temperatures fall outside the required parameters. 4. It is noted that the upright fridge has been cleaned during the audit. Implement a monitoring process to ensure that this is maintained. 5. Ensure that food temperature is monitored and recorded. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## Outcome 1.4: Safe and Appropriate Environment

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

#### Standard 1.4.2: 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

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| **Attainment and Risk:** PA High |
| **Evidence:** |
| The building, facilities, and furnishings are well maintained and suitable for the care and support of elderly, semi-dependent residents. Applicable building regulations and requirements are met. There is a current building warrant of fitness that expires on 16 June 2014. Suitable and sufficient equipment is provided to meet residents’ needs. There is a system in place to ensure the electrical safety of the environment, appliances and equipment. Improvement is required to ensure that all items of clinical equipment have regular functional checks and are calibrated where necessary. Improvement is required to ensure that lockable door handles are not installed on residents’ bedroom doors. Improvement is required to ensure that hot water temperatures in resident areas are monitored and maintained within safe parameters and that residents are protected from scalds from the boiling water zip in the dining room.  Residents have access to an outdoor deck with safety balustrades. Improvement is required to protect residents from falls down the external steps and a safety gate has been installed during the audit.  A previous improvement required under 1.4.1.1 in relation to labelling of chemicals containers has been effectively addressed. Collection and disposal of waste are in accord with infection control principles and comply with local body requirements. Improvement is required to ensure that the laundry, cleaning and waste storage areas are secured from access by wandering residents, cleaning and sanitizing chemicals are securely and safely stored, that the cleaning trolleys are securely stored when unattended, and that clean linen is delivered and dirty linen collected using different trolleys.  Appropriate processes are in place to maintain the safety and security of residents during an environmental emergency. All staff attend fire safety training at least annually. Staff have received training in managing relevant clinical emergencies but improvement is required to ensure that sufficient staff have current first aid certificates to roster one on each shift and that protocols are developed for management of relevant clinical emergencies. ARC requirements relating to D4.1b, D15.2e, D15.3c are not met. All other relevant ARC requirements are met. |

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

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The building, facilities, and furnishings are well maintained and suitable for the care and support of elderly, semi-dependent residents. Applicable building regulations and requirements are met. There is a current building warrant of fitness that expires on 16 June 2014. Suitable and sufficient equipment is provided to meet residents’ needs. Inspection and review of records indicates that electrical safety of the environment, appliances and equipment is tested and tags attached biennially. The scales are calibrated annually but the thermometers and sphygmomanometers have not been done and the two hoists have not had regular functional tests. There is no defined regime for regular cleaning of the hoist or the slings. |
| **Finding:** |
| The equipment maintenance system does not include all items of clinical equipment. For example there are no processes in place for - 1. Regular functional or electrical checks of the sling hoist or for regular cleaning of the hoist or the slings. 2. Regular calibration of the digital thermometer and the digital sphygmomanometer. |
| **Corrective Action:** |
| Implement a regime for regular functional checks and cleaning of the hoists and regular calibration of the digital thermometer and the digital sphygmomanometer. |
| **Timeframe (days):** 30 *(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.

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| **Attainment and Risk:** PA High |
| **Evidence:** |
| All interior fittings and furnishings are maintained in a safe condition. Hand rails are provided in all corridors, bathrooms and toilets. A variety of seating is available. There is adequate room for residents to use and store mobility aids. Some bedrooms have doors with a push button door handle lock which the resident may not be able to manipulate when they want to get out. A key is hung over the door in the corridor so the resident can lock the door when they leave the room and staff can also enter at will. The locks are to prevent unauthorised access by confused residents into other resident’s bedrooms but may also prevent residents from exiting their rooms as they wish, resulting in a restraint situation. There is no evidence that residents have consented to this arrangement. A boiling water Zip is installed in a tea bay in the residents’ dining room for use of residents and visitors. There is no means of protecting users from scalds when getting hot water from the zip and access is open to anyone entering the room. The temperature of the hot water cylinders is set at more than 60C. The tempering valves are set at 55C. The process for monitoring the temperature of hot water in residents’ areas has not been maintained since March 2013. Checks done during the audit indicate the hot water temperature in the resident areas on audit day is 42C.  Storage areas and cupboards including the switchboard cupboard are not secured from unwanted access The space in one unused bathroom used to store unused equipment is poorly structured for storage and equipment could tip and fall on those entering (visitors and residents). A previous improvement required under 1.4.1.1 in relation to labelling of chemicals containers has been effectively addressed. On inspection there is insufficient space in the cupboard in which cleaning and other chemicals are stored. Containers are stacked on top of each other, including those containing flammable liquids. The laundry, cleaning and rubbish storage areas are not secured and are readily accessible to wandering residents. There are bottles of cleaning and laundry fluid on the windowsill in the laundry. A cleaning trolley on which there are bottles of diluted Dettol that looks like milk is kept in an unsecured unused toilet when not in use. Improvement is required to ensure that the laundry, cleaning and waste storage areas are secured from access by wandering residents, cleaning and sanitizing chemicals are securely and safely stored, that the cleaning trolleys are securely stored when unattended, and that clean linen is delivered and dirty linen collected using different trolleys. Steps have been taken during the audit to control these hazards until permanent solutions can be implemented. Appropriate processes are in place to maintain the safety and security of residents during an environmental emergency. All staff attend fire safety training at least annually. There is appropriate equipment for management of basic first aid and CPR support until an ambulance can attend. Training related to relevant clinical emergencies has been provided but there are no documented protocols in place for response to clinical emergencies. Only five of 23 care staff have a current first aid certificate. There is no first aider rostered on afternoon shift six days a week. |
| **Finding:** |
| The indoor physical environment is not consistently safe for all residents. For example –  1. The doors to the laundry / cleaning area and to the external cleaning /rubbish storage area are not secured when the areas are unattended by staff.  2. Some bedrooms have doors with a push button door handle lock which some residents may not be able to manipulate when they want to get out. The locks are to prevent unauthorised access by confused residents into other resident’s bedrooms but may also prevent residents from exiting their rooms as they wish, resulting in a restraint situation. There is no evidence that residents have consented to this arrangement. 3. Store cupboards are not secured from unwanted access, including the switchboard cupboard. The space in one unused bathroom used to store unused equipment is poorly structured for storage and equipment could tip and fall on those entering (visitors and residents). 4. The same trolley is used to collect dirty linen and deliver clean linen at the same time.  5. A boiling water Zip is installed in a tea bay in the residents’ dining room for use of residents and visitors. There is no means of protecting users from scalds when getting hot water from the Zip and access is open to anyone entering the room. 6. The system for monitoring the temperatures of hot water in resident areas has not been maintained.  Hazardous chemicals are not all safely stored. For example –  1. Clear plastic pump bottles of hand sanitizer for use by staff are placed on hand rails in corridors throughout the facility where they are openly accessible by residents and could be mistaken for drinking bottles. 2. Containers of cleaning chemicals are stacked on top of each other on the floor of the cleaning cupboard, including a container labelled inflammable liquid. 3. Bottles of cleaning fluids are stored on the window sill in the laundry that is openly accessible to residents. These were removed to a cupboard during the audit.  4. The cleaning trolley is put away in an unused, unsecured toilet when not in use. Bottles of diluted Dettol that looks like milk are left on the cleaning trolley and are readily accessible to residents.  There are insufficient processes in place for management of clinical emergencies, for example:  1. There are no documented protocols in place for response to clinical emergencies apart from CPR procedures. 2. Not every shift has a staff member with a current first aid certificate rostered on duty. |
| **Corrective Action:** |
| Corrective Action: A - Physical environment: 1. Install mechanisms on the doors to the laundry / cleaning area and to the external cleaning /rubbish storage area to prevent access by residents when the areas are unoccupied. 2. Remove locking door handles from resident’s bedrooms. This has been actioned during the audit. 3. Secure storerooms from unwanted access. Ensure that storage areas are appropriately fitted to prevent stored items from falling over. 4. Use separate trolleys for delivering clean linen and for removing dirty linen. 5. Provide mechanisms to ensure that residents and visitors are protected from scalds when getting boiling water from the Zip in the dining room. 6. Consistently maintain the system for monitoring the temperatures of hot water in resident areas.  B - Hazardous chemicals: 1. Remove the pump bottles of hand sanitizer from the corridors and install suitable fixed dispensers to prevent access by residents or visitors who may drink the fluid. 2. Rearrange the chemicals storage cupboard to eliminate the need to stack containers on top of each other. Store inflammable liquids away from cleaning solutions. 3. Containers of cleaning fluid on the laundry windowsill have been removed to a secure cupboard. Maintain secure storage of chemicals in the laundry. 4. Store the cleaning trolley in a secure area.  C - Clinical Emergency Processes: 1. Develop protocols for management of clinical emergencies. 2. Ensure that sufficient care staff have a current first aid certificate to provide at least one on every shift. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Residents have access to an outdoor deck. There are safety balustrades in place but there is open access to a steep set of stairs leading down from the deck to the garden. |
| **Finding:** |
| There is no means of preventing residents from falling down a steep set of stairs leading down from the deck to the garden. |
| **Corrective Action:** |
| To protect residents from falls down the external steps a safety gate has been installed during the audit. No further action is necessary. |
| **Timeframe (days):** 30 *(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

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The facility demonstrates that the use of restraint is actively minimised. The principal nurse (PN) reports that they have no residents on restraints or enablers. Further interview reveals that one resident uses a bed pole which is an enabler. The resident came from the hospital with this bed pole and uses it to move in and out of the bed. No restraint assessment has been completed and it is not entered in the restraint register. Staff members interviewed are not aware of what is an enabler.  The previous requirement for improvement relating to Restraint Minimisation and Safe Restraint Practice Policy definitions of both restraint and an enabler is congruent with the definitions in NZS 8134.0 as sighted in the new policy. |

##### 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.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The bed pole used by one resident as an enabler has not been managed in accordance with the documented restraint policy. |
| **Finding:** |
| 1. A restraint assessment has been completed for the resident using the bed pole as an enabler.  2. The restraint register and record do not include the resident with the enabler.  3. Staff are not aware what is an enabler, for example the “bed pole” used by the resident |
| **Corrective Action:** |
| 1. Ensure that a restraint assessment, evaluation and risk management plan is completed for the resident.   2. Ensure that enablers are entered in the restraint register.  3. Provide further education for staff about use of enablers.(Refer to 1.2.7.5) |
| **Timeframe (days):** 90 *(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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The Waratah Retirement Home has an infection control committee chaired by the administration officer. Infection surveillance is part of the monthly staff meeting. They have purchased a Bug Control Manual last October 2013. All infections i.e. respiratory tract, urinary tract, skin/soft tissue are monitored and recorded in the antibiotics register. The infection control officer reports that they have a new system in the computer which will generate the monthly infection control data. The type of surveillance is appropriate to the size and complexity of the facility.   Results of the surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are not acted upon and are not evaluated in a timely manner. The PN reports that they monitor infections and antibiotics use in the facility but no documented evaluation is sighted in the monitoring sheet. There are inconsistencies in reporting to the staff members about surveillance outcomes.   There is a suitable documented surveillance process in place but it has not been implemented.   1. Not all infections are included in the surveillance process, for example five cases of scabies infection reported in May 2013 have not been recorded in the surveillance process.  2. Treatment, duration and resolution are not included in the surveillance process and record.   3. Surveillance data is not further analysed to identify incidence and trends.  4. There is no evidence that surveillance information and outcomes are reported to staff.  Infection control policies and procedures provided in the staff resource room are out of date and do not comply with current best practice, for example the MRSA Guidelines 2000. Policies and procedures do not contain sufficient detail to provide clear guidelines for staff in maintaining infection control, in particular the containment and management of an outbreak of infection. It is acknowledged that the latest version of the Bug Control Manual has just been obtained, and that advice is being received from a DHB nurse advisor. |

##### 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.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **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.

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Results of the surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are not acted upon and are not evaluated in a timely manner. The PN reports that they monitor infections and antibiotics use in the facility but no documented evaluation is sighted in the monitoring sheet. There are inconsistencies in reporting to the staff members about surveillance outcomes.   There is a suitable documented surveillance process in place but it has not been implemented.   1. Not all infections are included in the surveillance process, for example five cases of scabies infection reported in May 2013 have not been recorded in the surveillance process.  2. Treatment, duration and resolution are not included in the surveillance process and record.   3. Surveillance data is not further analysed to identify incidence and trends.  4. There is no evidence that surveillance information and outcomes are reported to staff. |
| **Finding:** |
| There is a suitable documented surveillance process in place but it has not been implemented.   1. Not all infections are included in the surveillance process, for example five cases of scabies infection reported in May 2013 have not been recorded in the surveillance process.  2. Treatment, duration and resolution are not included in the surveillance process and record.   3. Surveillance data is not further analysed to identify incidence and trends.  4. There is no evidence that surveillance information and outcomes are reported to staff. |
| **Corrective Action:** |
| Fully implement the documented surveillance process to ensure that -  1. All infections are included in the surveillance process.  2. Treatment, duration and resolution are included in the surveillance record.   3. Surveillance data is further analysed to identify incidence and trends.  4. Surveillance information and outcomes are reported to staff. |
| **Timeframe (days):** 30 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |