

Norfolk Lodge Waitara Limited

Current Status: 27 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

Norfolk Lodge Rest Home is certified to provide rest home and dementia level care. There were 31 residents occupying 40 available beds on the day of the audit. There is a nurse manager on site during week days and on call and trained caregivers provide on-site support for residents.

The improvements required at the certification audit around fencing of the swimming pool and medication administration have been addressed.

This audit identified improvements required related to; reassessments, short term care planning, complaints register, integration of resident records, incident management, and security of cleaning chemicals.

Audit Summary as at 27 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 27 November 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Organisational Management as at 27 November 2013

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Continuum of Service Delivery as at 27 November 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Safe and Appropriate Environment as at 27 November 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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Restraint Minimisation and Safe Practice as at 27 November 2013

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Infection Prevention and Control as at 27 November 2013

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

Introduction

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

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

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

Audit Report

Legal entity name:	Norfolk Lodge Waitara Ltd
Certificate name:	Norfolk Lodge Rest Home
Designated Auditing Agency:	HDANZ
Types of audit:	Surveillance
Premises audited:	30 Princess Road, Waitara
Services audited:	Rest Home, Dementia
Dates of audit:	Start date: 27 November 2013 End date: 28 November 2013
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	31

Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	6
Other Auditors		Total hours on site		Total hours off site	
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXXX			Hours	2

Sample Totals

Total audit hours on site	12	Total audit hours off site	8	Total audit hours	20
Number of residents interviewed	4	Number of staff interviewed	7	Number of managers interviewed	1
Number of residents' records reviewed	4	Number of staff records reviewed	5	Total number of managers (headcount)	1
Number of medication records reviewed	8	Total number of staff (headcount)	41	Number of relatives interviewed	5
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	0

Declaration

I, XXXXX, Director of Christchurch, hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

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

Dated Friday, 14 February 2014

Executive Summary of Audit

General Overview

Norfolk Lodge Rest Home is certified to provide rest home and dementia level care. There were 31 residents occupying 40 available beds on the day of the audit. There is a nurse manager on site during week days and on call and trained caregivers provide on-site support for residents. The improvements required at the certification audit around fencing of the swimming pool and medication administration have been addressed. This audit identified improvements required related to; reassessments, short term care planning, complaints register, integration of resident records, incident management, and security of cleaning chemicals.

Outcome 1.1: Consumer Rights

Accidents, incidents and complaints alert staff to their responsibility to notify family/next of kin of any event that occurs and family state that they are fully informed at all times. An interpreter's policy is in place and external assistance is available if necessary. The complaints procedure is provided to residents and relatives as part of the admission process and the complaints register is up to date with written complaints with evidence of timely resolution of complaints.

An improvement is required to documentation of verbal complaints on the complaints register.

Outcome 1.2: Organisational Management

Norfolk Lodge Rest Home has a quality and risk management system documented. Key aspects of the quality improvement and risk management programme include health and safety, implementation of an internal audit schedule and surveillance of infections. The service has policies and procedures that are reviewed annually. The service has human resources procedures for staff recruitment and employment and there is an implemented orientation programme and annual training schedule that is implemented. Staffing levels safely meet the needs of the residents with staff in the dementia unit trained in dementia care.

The improvement required to the swimming pool fencing has been addressed.

Improvements are required to the following: review and follow up of incident forms, ensuring that family are documented as being informed after an incident, integration of resident records.

Outcome 1.3: Continuum of Service Delivery

The service is moving to document all care planning on InterRAI. There is a documented assessment process and there is an information pack available for residents/families at entry. Assessments and care plans are individualised. The service facilitates access to other medical and non-medical services. Improvements are required around reassessments of the resident six monthly, short term care planning and referral to a general practitioner in a timely manner when changes are noted.

Staff provide a varied activity programme with residents actively engaged at all times.

There is a medication management policy. The previous improvement required around caregivers checking prescription charts before administering medicines has been addressed.

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	Seven of nine incident forms reviewed do not note that family have been informed and one family member stated that she was not informed of an incident of her family member in the dementia unit.	Ensure that family are informed and documentation reflects this.	90
HDS(C)S.2008	Standard 1.1.13: Complaints Management	The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low			
HDS(C)S.2008	Criterion 1.1.13.3	An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	Verbal complaints are not currently recorded in the complaints register. This was addressed on the day of audit.	Ensure that verbal complaints are included in the complaints register.	90
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			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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	(i) Two incident forms reviewed include documentation of incidents involving two or three residents. There is only one incident form documented and it is difficult to identify events and any issues for individual residents. (ii) Evidence of a clinical review by the nurse manager on the incident forms is not documented. (iii) One resident fell on her head. There is no evidence of neurological observations having been completed. (iv) Incidents documented in a variety of places e.g. the communications book and progress notes do not necessarily get documented on incident forms.	(i) Ensure that events and issues related to each resident involved in an incident are documented clearly. (ii) Document a clinical review on the incident forms. (iii) Observe and take neurological observations for any resident where there has been a possible incident involving the head. (iv) Document all incidents on incident forms.	60
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 Low			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
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 Low	Not all care needs are documented in a timely manner e.g. a wound assessment and plan is not documented for a resident with a skin tear, a short term plan or reference to the care required following a colonoscopy is not documented noting that the instructions are in the hospital discharge notes and the nurse manager and caregivers are able to describe care required.	Ensure that care is documented in a timely manner when changes occur.	90
HDS(C)S.2008	Criterion 1.3.3.4	The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	There is a lack of an integrated resident file that ensures continuity of service delivery for each resident.	Ensure that there is an integrated resident file to provide continuity in service delivery.	90
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low			
HDS(C)S.2008	Criterion 1.4.2.4	The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	The cleaner's trolley in the dementia unit was observed to be unattended three times on the morning of the audit with the cleaner not able to sight the trolley.	Ensure that the cleaner's trolley is kept within eyesight at all times in the dementia unit.	7

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Outcome 1.1: Consumer Rights

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

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

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

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

Attainment and Risk: PA Low

Evidence:

The policy on open disclosure describes requirements to share information, including adverse events, with residents and their family. Residents and their family are provided with a welcome pack at entry that includes the admission agreement, information about the service as a secure dementia unit and rest home and information about complaints and open disclosure.

Contact with the family/nominated representative is expected to be recorded on the accident and incident form (sighted on two of nine completed forms). D16.4b Four of the five family interviewed (two dementia and two rest home) confirm that they are informed of any incident in a timely manner – one stated that she had not been informed about an incident for her family member in the dementia unit prior to her coming in for an informal visit the day after when she saw the family member with bruising.

The policy on interpretation and translation services includes contact information for translation services.

There are no residents currently requiring an interpreter.

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.

D16.1b.ii Residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

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

An improvement is required to documentation on incident forms of family being informed.

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

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

Attainment and Risk: PA Low

Evidence:

Two of nine incident forms reviewed include that the family has been contacted after an incident. Four of five family members state that they are informed of any incidents with one family member stating that she was not informed after an incident resulting in bruising.

Finding:
Seven of nine incident forms reviewed do not note that family have been informed and one family member stated that she was not informed of an incident of her family member in the dementia unit.
Corrective Action:
Ensure that family are informed and documentation reflects this.
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

Attainment and Risk: PA Low
Evidence:
Family are informed of their right to complain and the service facilitates their ability to do so. There is a clearly defined complaints procedure as part of the policy, which complies, with the code of rights. The policy states that all complainants will be notified within 5 working days on receipt of complaint, and other timeframes are in line with the Code. Five of five family members interviewed (three dementia and two rest home) note that they were aware of the complaints process but said that they had not had the need to complain. Family interviewed confirm that they are delighted with the service provided. There has been one complaint lodged with the Health and Disability Commission with a letter dated 26/9/13 indicating that there is no further action required. The complaint was reviewed as per the Ministry of Health instructions for the audit and evidences that all corrective actions have been

addressed.

The complaints register is available to document any complaints and currently documents written complaints.

D13.3h. A complaints procedure is provided to resident as able and to families within the information pack at entry.

E4.1biii. There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on minimising restraint, behaviour management and encouragement for families to complain if there are any issues. This is included in the information pack provided to family when entering the service.

Four of four caregivers interviewed including two from the dementia unit and two from the rest home are able to describe the complaints process.

An improvement is required to documentation of verbal complaints in the complaints register.

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

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

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

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

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

Attainment and Risk: PA Low
Evidence: There is a complaints register that includes written complaints.
Finding: Verbal complaints are not currently recorded in the complaints register. This was addressed on the day of audit.
Corrective Action: Ensure that verbal complaints are included in the complaints register.
Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: FA

Evidence:

Norfolk Lodge is a privately owned residential care facility and specialised dementia unit. The company was founded March in 2001. Norfolk Lodge Rest Home provides rest home and dementia level care for up to 40 residents. On the day of the audit, there are 15 residents in the 17 bed dementia unit and 16 rest home residents (total 31 residents). There is a nurse manager (registered nurse with a current APC) who is involved on a daily basis on site during weekdays and on call. The nurse manager has many years' experience in aged care and has been in the nurse manager role for nine years. The service has a mission and values, organisation objectives and a documented quality plan 2013. This is reviewed by the nurse manager. ARC E2.1 The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life. Discussion with the nurse manager and all other staff including the care team leader, four caregivers and diversional therapist indicates the service concentrates on engaging residents in household jobs with support for activities of daily living. Five family interviewed (three dementia and two rest home) confirm that the philosophy is lived by the service through the passion and commitment of the manager and staff. ARC,D17.3di The manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility for residents with dementia.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The policy manual includes a range of policies related to quality and risk management. The business plan describes quality objectives, strategies to achieve outcomes and assigned responsibility. Progress against goals is completed by the nurse manager as part of the management and staff meeting. There are four to six weekly staff meetings in the service to review progress against the quality and risk management programme. The meetings include adverse events reported for the period, complaints, infection control, internal and external audits, family feedback, health and safety and any issues. The audit schedule for 2013 is followed each month and includes cleaning, medicine administration, personal care and grooming, documentation, continence, hand washing, activities, privacy, laundry, food services. Corrective actions are documented with evidence of resolution. There are annual family satisfaction surveys – last collated February 2013 with 95% satisfaction. There are also post entry satisfaction surveys six weeks after entry and the results are collated. Staff are invited to provide suggestions/feedback through the six weekly staff meetings and staff state that they are kept well informed about quality related activity and appreciate the range of opportunities available to contribute to discussion (confirmed during interview with four of four caregivers including two from the rest home and two dementia). Document control and control of documents policies guide policy/document control. A checklist documents the date of review for all policy manuals. Health and safety policies are implemented and monitored by through staff, management and the activities meetings. Risk management, hazard control

and emergency policies/procedures are in place. Hazard identification and control is up to date with a hazard register in place.
 There are family and resident meetings held throughout the year and the diversional therapist facilitates these.
 The service focuses on quality improvement that enhances the service for residents with dementia.
 There is a swimming pool on the premise that has been re fenced.
 The previous improvement required around the swimming pool fencing has been addressed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

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

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

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

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: PA Moderate
Evidence: <p>Policies on incident reporting and accident reporting and investigation procedures describe the adverse event reporting process. Accident and incident reports are investigated by the manager and signed off as being reviewed with any actions documented.</p> <p>Accident and incident reports document the event, the date, those involved, the investigation, suggested and completed actions and whether the family member has been informed (sighted in two of nine accident/incident reports – link 1.1.9).</p> <p>Accident and incident data is discussed at staff meetings as sighted in minutes for 2013.</p> <p>The staff meet six weekly and incidents are discussed.</p> <p>The manager is aware of notification responsibilities and is able to describe these.</p> <p>Improvements are required to the incident reporting system including the following: documentation of the incident forms when two or more residents are involved in a single incident, documentation of clinical review by the nurse manager, follow up observations for a head injury, documentation of all incidents on incident forms.</p>

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

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

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

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

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

Attainment and Risk: PA Moderate
Evidence: Incident forms are documented with nine reviewed on the day of the audit. All are signed off as being reviewed by the nurse manager. Incidents are documented in a variety of places including progress notes, on incident forms and in the communication book (refer 1.2.9).
Finding: (i) Two incident forms reviewed include documentation of incidents involving two or three residents. There is only one incident form documented and it is difficult to identify events and any issues for individual residents. (ii) Evidence of a clinical review by the nurse manager on the incident forms is not documented. (iii) One resident fell on her head. There is no evidence of neurological observations having been completed. (iv) Incidents documented in a variety of places e.g. the communications book and progress notes do not necessarily get documented on incident forms.
Corrective Action: (i) Ensure that events and issues related to each resident involved in an incident are documented clearly. (ii) Document a clinical review on the incident forms. (iii) Observe and take neurological observations for any resident where there has been a possible incident involving the head. (iv) Document all incidents on incident forms.
Timeframe (days): 60 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

There are policies on orientation, recruitment and credentialing. Job descriptions are in place and describe the position, functional relationships, primary objectives, key tasks and expected results for each role. The nurse manager has a current practising certificate - sighted. Recruitment processes are described by the nurse manager as including an application process, interview and referee checks.

All new employees complete a documented orientation process, which includes working with a support person of the same role buddying the new staff member. The orientation programme covers the essential components of the service provided including how to work with residents with dementia.

Four of four caregiver's state that they have had an appropriate recruitment, interview and employment process with an orientation completed that comprehensively covered key areas of the service. They also state that they have training monthly and all training is relevant to their roles.

The training plan is implemented with the following topics completed since January 2013; infection control, safe food handling, challenging behaviour, restraint, medication administration, wound management, clinical documentation. Topics related to clinical topics are facilitated by the nurse manager.

External facilitators are used when possible e.g. pharmacy.

Training records for five of five staff members indicate that they attend all programmes.

All staff working in the dementia unit are trained in dementia care or are enrolled in the Health Education dementia care training programme.

Training records are retained on individual staff files with attendance records kept for each session.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The service has a service management policy and rosters sighted indicate that staff are allocated appropriately.

There are a total of 41 staff including the nurse manager, four trained diversional therapists, two cooks, maintenance, one administrator, one gardener, four cleaners, 24 caregivers and one care team leader.

Staffing for up to up to 31 residents on the day of audit is implemented as per the following roster:

Dementia unit: AM – 5 caregivers (two full); PM – one caregiver 3pm-11pm and one caregiver 3pm-9pm; night – one caregiver 11pm-7am with the ability to phone the rest home at any time.

Rest Home: AM: One full and one short shift caregivers; PM – one caregiver 3pm-12pm and one 3pm-8pm; night – one caregiver 11-7pm.

There is always a sleepover caregiver as well who stays on site. Caregivers interviewed confirm that the sleepover always wakes when called and often comes into the dementia unit at night to 'check' (confirmed by a caregiver who also does night shift).

All residents interviewed (five rest home), five of five family and staff state that there are sufficient staff on site at any time including caregivers interviewed that cover all shifts and areas.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 1.3: Continuum of Service Delivery

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

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

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

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

Attainment and Risk: PA Low

Evidence:

Assessment, planning, evaluation, review and exit are undertaken by the registered nurse with input from the diversional therapist, manager and caregivers. Service delivery is undertaken by care giving staff, the diversional therapist, the manager and the registered nurse.

Four of four files reviewed including two dementia and two rest home include an initial assessment completed within 24 hours, an initial care plan completed within 48 hours and GP review within 48 hours of admission. All have a long term first developed within three weeks of admission and all have a care plan reviewed six monthly.

Residents and the family members interviewed indicate that they are involved in the assessment and planning process.

Residents have access to a GP with residents having a three monthly review or more frequent review as required. The nurse manager communicates well with the GP as confirmed by the GP interviewed.

Five of five family members interviewed including three dementia unit and two rest home report they are aware of all matters pertaining to the resident. The care plan is kept in the resident's file and made available to specialists and allied health professional.

Four of four caregivers and the nurse manager can describe hand over processes.

D16.2, 3, 4: The four files reviewed identified that in all files the initial assessment and plan has been dated and signed.

There is evidence of a reassessment and the care plans are reviewed using an exception reporting approach. Note that pressure area, pain, mini nutritional and falls risk assessments are completed three to six monthly as well as completion of InterRAI care plans.

Tracer 1 dementia: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer 2 rest home: XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Improvements are required to documentation of care when changes are identified and integration of resident records.

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

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

Attainment and Risk: FA

Evidence:

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

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

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

Attainment and Risk: PA Low
Evidence: There is reference in one file in the progress notes to dressing of a skin tear and an incident form records the initial fall and the resulting skin tear. There are templates for specialised assessments e.g. pain, continence, falls, mini nutritional along with the service now using the InterRAI assessment and care plan. The care plan is reviewed six monthly and documented using an exception reporting format.
Finding: Not all care needs are documented in a timely manner e.g. a wound assessment and plan is not documented for a resident with a skin tear a short term plan or reference to the care required following a colonoscopy is not documented noting that the instructions are in the hospital discharge notes and the nurse manager and caregivers are able to describe care required.
Corrective Action: Ensure that care is documented in a timely manner when changes occur.
Timeframe (days): 90 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

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

Attainment and Risk: PA Low
Evidence: Resident information is kept in a variety of folders e.g. a main resident file, use of the communication book to document progress notes, incidents identified in progress notes and/or in the communication book and not necessarily documented on incident forms, separate information around bowel movements etc.
Finding: There is a lack of an integrated resident file that ensures continuity of service delivery for each resident.

Corrective Action:

Ensure that there is an integrated resident file to provide continuity in service delivery.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

Attainment and Risk: FA

Evidence:

The care being provided is consistent with the needs of residents (refer 1.3.3.3) and this is evidenced by discussions with four caregivers (two dementia and two rest home), five relatives (three dementia and two rest home) and the nurse manager. The general practitioner interviewed on the day of audit is complimentary of the care residents receive and states that staff inform the general practitioner in good time of any concerns they may have regarding residents health status.

Appropriate interventions are described in the care plans and have been documented as being completed in the progress notes.

Staff including the diversional therapist and caregivers are seen to be actively engaging residents in activities as per their care plan during the day of the audit.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D16.5d Resident files reviewed identified that the individual activity assessment is completed on entry to the service. This includes a social history.

Residents are quick to engage or not engage which indicates likes and dislikes.

The activity assessment and care plan is developed with the relative whenever possible and reviewed at least six monthly. The plans are individualised and cover a 24 hour period.

Four of four files reviewed including two dementia and two rest home files reviewed include an individualised activity plan with reviews completed in a timely manner.

Caregivers were observed at various times through the day diverting residents from behaviours particularly in the dementia unit. The programme observed was appropriate for older people with dementia and one to one care needs with residents actively engaged in activities including crafts, exercise, walking etc. The diversional therapist is passionate about making a difference in resident lives through activity and all staff including the nurse manager are committed to providing activities to keep residents busy, engaged and active. The environment has been designed to create activities for people with an outdoor area that includes gardens, areas to walk in and paths that lead back to the inside. The swimming pool is not accessible to residents in the dementia unit.

An attendance register is kept for each individual resident detailing their engagement in activities.

Residents are observed to be really enjoying the programme and activities.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

D16.4a Evaluation timeframes are specified in policies and procedures. Evaluations are conducted by the nurse manager three to six monthly (link 1.3.3.3). Caregivers monitor resident's progress on a shift-by-shift basis and report any concerns to the nurse manager with progress notes recording progress against goals and information around activities.

Short term care plans are used in the rest home and dementia unit as sighted for the following: removal of a wart, weight loss and issues related to challenging behaviour around sexuality that have recently arisen.

Any changes to the long term care plan are dated and signed.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

Attainment and Risk: FA
<p>Evidence:</p> <p>Policies and procedures on medicine management include prescribing and dispensing, self-administration, storage and disposal, staff administration, controlled drugs, staff training and competencies and monitoring medication errors.</p> <p>Controlled drugs are in a locked cupboard in a locked room noting that these are located only the in the rest home. There are no residents using controlled drugs during the audit.</p> <p>Eight of eight medication files checked indicate that all are documented correctly in the administration records.</p> <p>All include photo identification and all relevant files have allergies and sensitivities recorded in the medication file and the resident file.</p> <p>Medicines for residents are received from the contracted pharmacy and checked on entry to the service by the nurse manager.</p> <p>Signatures of staff can be identified.</p> <p>All staff responsible for medication management have completed medication competencies and records are maintained.</p> <p>Eight of eight medication files have been reviewed three monthly and this is verified by the GP interviewed.</p> <p>There are no residents self-administering medication either in the dementia or rest home units and the nurse manager confirms that this practice is not appropriate in the dementia unit.</p> <p>A caregiver was observed to sign for medications at the time of administering the drugs, eye drops are dated (sighted) and there is no evidence of transcribing of information.</p> <p>Eight of eight medication files indicate that the general practitioner signs every prescription entry.</p> <p>The requirement from the previous audit around caregivers checking the prescription chart prior to administration has been addressed.</p>

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>Fluids are provided with each meal, jugs of water are available in resident rooms and morning tea, afternoon tea and supper is provided. Any dietary requirements are identified in the dietary profile, mini nutritional assessment and through documentation in InterRAI, which is undertaken on admission by the nurse manager and updated as required. A copy is kept in the individual resident file and the cook has a copy. The cook interviewed explained that the kitchen staff can cater for all dietary requirements and there are instructions related to what plate to use, if food should be cut up, and the type and portion size of the meal. There are no special diets or residents requiring dietary supplements at the moment. The kitchen is clean and has cooking appliances for the numbers to be catered for. All food supplies are delivered on a regular basis to meet the menu requirements. Food is stored safely, labelled with contents and expiry dates are monitored. There are daily temperature recordings of the fridge/freezer and food</p>

temperatures are recorded with documentation indicating that all food temperatures are in the correct range or corrected if not.
 All kitchen staff have attended training around nutrition and hydration in April 2013.
 Five of five family members interviewed including three dementia unit and two rest home and residents in the rest home confirm that the food meets the approval of their family member from their observation and residents appear to enjoy the meal at lunchtime.
 There is an annual food service audit – last completed in March 2013.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

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

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

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

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

Attainment and Risk: PA Low
Evidence: <p>A current Building Warrant of fitness is posted in a visible location at the entrance to the facility and is current (expiry date 3 May 2014). There have been no building modifications since the last audit however there have been room refurbishments.</p> <p>There is a planned maintenance schedule implemented.</p> <p>Electrical equipment is checked by an external contractor bi-annually – last in March 2012 with a schedule in place for March 2014.</p> <p>D15.3d, E3.4d The lounge area is designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounge in the rest home and lounge in the dementia unit on the day of the audit.</p> <p>Interviews with four of four caregivers and the nurse manager confirm there is adequate equipment including lifting belts.</p> <p>E3.3e: There are quiet areas throughout the facility – both rest home and dementia unit for resident and visitors to meet and there are areas that provide privacy when required.</p> <p>There are safe outside areas that is easy to access for residents and family members. These include outdoor shade, tables and chairs.</p> <p>E3.4.c The dementia unit is secure with a large gate and intercom.</p>

There is sufficient space in both the rest home and dementia unit to allow residents to move around the facility freely. All bedrooms have sufficient space for equipment and for staff to work. The hallways have hand rails and are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas and throughout the facility.
 ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, lifting aids. Interviews with four of four files reviewed including two dementia and two rest home confirmed there is adequate equipment.
 An improvement is required to monitoring of the cleaners trolley.

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

All buildings, plant, and equipment comply with legislation.

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

Attainment and Risk: PA Low
Evidence: There is a trolley for the cleaners to take products and tools out with them. There is an expectation that the trolley is supervised at all times by the cleaner especially in the dementia unit as confirmed by the nurse manager. The cleaner in the rest home was observed to take the trolley into rooms and to keep the trolley in eyesight at all times.
Finding: The cleaner's trolley in the dementia unit was observed to be unattended three times on the morning of the audit with the cleaner not able to sight the trolley.
Corrective Action: Ensure that the cleaner's trolley is kept within eyesight at all times in the dementia unit.
Timeframe (days): 7 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

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

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
Evidence: <p>Policies and procedures for restraint minimisation with a focus on a restraint free environment and safe practice are fully implemented. All residents undergo a detailed risk assessment and care plans are implemented to ensure that restraint is not used. Staff are trained in the use of enablers. The policy specifies that enablers are to be used on a voluntary basis but no enablers are in use currently. Staff receives on-going education in the policy for restraint minimisation and the management of challenging behaviour – last provided in March and October 2012 with this planned for December 2013. There is no use of restraint at Norfolk Lodge Rest Home.</p>

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

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

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

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA
Evidence: Surveillance frequency and type is set out in policy and determined by the organisation's infections control policies and procedures that are reflective of the service offered at this rest home. Surveillance data is undertaken as required in the Health and Disability Services Standards Infection and Prevention Control standards 2008. Infection control data is collected on site and resolution of the infection. There is monthly documentation of infections and a graph that enables trends to be analysed. The nurse manager interviewed has a good understanding of the surveillance system and significance of collecting the data with evidence that the data is used to improve service delivery. An antibiotic usage summary is kept up to date.

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

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

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

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

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

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