# Torbay Rest Home Limited

## Current Status: 17 December 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

Torbay Rest Home provides rest home level care for up to 42 rest home residents. At the time of the audit, there are 38 residents including two residents receiving respite level care. The clinical nurse manager has been in the position for a year and is supported by the owners who provide oversight with weekly visits. The clinical nurse manager has over 18 years prior management experience in aged care.

Improvements are required around the quality programme, performance appraisals, general practitioner review of medication, documentation of interventions, and monitoring of freezer temperatures.

## Audit Summary as at 17 December 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 17 December 2013

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

### Organisational Management as at 17 December 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 low risk. |

### Continuum of Service Delivery as at 17 December 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 medium or high risk and/or unattained and of low risk. |

### Safe and Appropriate Environment as at 17 December 2013

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

### Restraint Minimisation and Safe Practice as at 17 December 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. |

### Infection Prevention and Control as at 17 December 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. |

# 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:** | Torbay Rest Home Ltd |
| **Certificate name:** | Torbay Rest Home |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | HDANZ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Types of audit:** | Surveillance | | | |
| **Premises audited:** | 102 Glenvar Road, Torbay, Auckland | | | |
| **Services audited:** | Rest home | | | |
| **Dates of audit:** | **Start date:** | 17 December 2013 | **End date:** | 17 December 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:** | 38 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXX | **Hours on site** | 8 | **Hours off site** | 5 |
| **Other Auditors** |  | **Total hours on site** | 0 | **Total hours off site** | 0 |
| **Technical Experts** |  | **Total hours on site** | 0 | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 8 | Total audit hours off site | 7 | Total audit hours | 15 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 6 | Number of staff interviewed | 6 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 39 | Number of relatives interviewed | 1 |
| Number of residents’ records reviewed using tracer methodology | 1 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of 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 Wednesday, 19 February 2014

## **Executive Summary of Audit**

|  |
| --- |
| **General Overview** |
| Torbay Rest Home provides rest home level care for up to 42 rest home residents. At the time of the audit, there are 38 residents including two residents receiving respite level care. The clinical nurse manager has been in the position for a year and is supported by the owners who provide oversight with weekly visits. The clinical nurse manager has over 18 years prior management experience in aged care.  Improvements are required around the quality programme, performance appraisals, general practitioner review of medication, documentation of interventions, and monitoring of freezer temperatures. |

|  |
| --- |
| **Outcome 1.1: Consumer Rights** |
| Torbay Rest Home provides care and support that focuses on the individual with residents and relatives praising the services provided. Family state that they are informed of any incidents. Complaints processes are implemented and complaints and concerns are actively managed and documented with a complaints register completed by the clinical nurse manager. The service encourages the documentation of verbal complaints as a tool to improve quality of service delivery. |

|  |
| --- |
| **Outcome 1.2: Organisational Management** |
| Torbay Rest Home provides rest home level care. The clinical nurse manager has been employed for a year in the service and is supported by a registered nurse who provides 20 hours a week support. Caregivers are employed as per the staffing policy and residents and family state that there staff are knowledgeable and skilled.  The service has an implemented internal audit programme. Intermittent staff meetings occur, and aspects of the quality and risk management programme are discussed with data presented. This includes infections and infection control, complaints, incidents and accidents, staff, resident issues. Improvements are required to the following: regular staff meetings, satisfaction survey and corrective actions documented with evidence of resolution for issues identified. |

|  |
| --- |
| **Outcome 1.3: Continuum of Service Delivery** |
| Assessments, care plans and evaluations are completed by the clinical nurse manager or the registered nurse. Residents/relatives are involved in planning and evaluating care. Residents and relatives interviewed comment positively on the care delivered at the service. Care plans demonstrate service integration, are individualised and are evaluated six monthly.  The activities coordinator provides an activities programme over 18 hours a week that is varied and interesting. Staff responsible for the administration of medication are competency assessed annually.  All meals are prepared on site, are nutritious and well presented. Individual and special dietary needs are catered for. Residents interviewed are complimentary about the meals provided.  Improvements are required to care planning around documentation of interventions for residents, documentation of review of medications by the general practitioner at least three monthly and to monitoring of freezer temperatures. |

|  |
| --- |
| **Outcome 1.4: Safe and Appropriate Environment** |
| The building holds a current warrant of fitness, which expires on 30 June 2014. There is a planned maintenance programme in place. All equipment is calibrated. There is sufficient space to allow the residents to freely move around the facility using mobility aids |

|  |
| --- |
| **Outcome 2: Restraint Minimisation and Safe Practice** |
| The service has a restraint free philosophy and there are no restraints or enablers used. All staff have had training around restraint, enablers and management of challenging behaviours in 2013 |

|  |
| --- |
| **Outcome 3: Infection Prevention and Control** |
| Infection control policies and procedures are documented. The infection control co-ordinator (registered nurse) is responsible for implementing the infection control programme. Infection surveillance is conducted to identify trends and results of analysis of data used to improve service delivery. |

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 10 | 0 | 5 | 1 | 0 | 0 |
| **Criteria** | 0 | 34 | 0 | 6 | 1 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 60 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| 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 Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.3.5 | Key components of service delivery shall be explicitly linked to the quality management system. | PA Low | Staff meetings are held irregularly throughout the year and restraint is not a set agenda item. | Ensure that staff meetings are held regularly throughout the year as scheduled with restraint included as an item for discussion. | 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 Low | Corrective actions and evidence of resolution are not documented when issues arise. | Document corrective actions with evidence of resolution. | 90 |
| 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 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Two of five files do not include a current annual staff performance appraisal. | Ensure that all staff have a current performance appraisal annually. | 180 |
| 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 |  |  |  |
| 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 | Specialised assessment tools are not used at times when changes in care needs requires further investigation e.g. pain assessment for one resident with continued back pain, dietary assessment for one resident with weight loss. | Document and use specialised assessment tools when required. | 90 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | (i)Wound management plans or short-term care plans are not documented for residents with skin tears. (ii) Interventions are not adequately documented in the care plan or in short term plans for weight loss and back pain. | Ensure that care plans document specific care and interventions for the following: (i) Wound management plans or short-term care plans for residents with skin tears. (ii) Interventions the care plan or in short term plans for weight loss and back pain. | 60 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.6 | 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 | Four of 12 files do not show that the general practitioner has reviewed medication three monthly. Clinical notes documented by the general practitioner reviewed evidence review of the resident at least three monthly however notes do not indicate that medication has been specifically reviewed as part of the consultation. | Ensure that there is documentation that indicates that the general practitioner has reviewed medication at least three monthly. | 60 |
| 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 Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.13.1 | Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | The two freezers are not checked to ensure that temperatures are in the appropriate range. | Ensure that freezer temperatures are within normal range as per policy. | 60 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

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

## **Outcome 1.1: Consumer Rights**

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on first contact with the family/resident.  D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement through the agreement and in discussion with the clinical nurse manager.  D16.4b The one family member interviewed stated that they are always informed when their family members health status changes. The facility has an interpreter policy and procedures available for access to interpreter services and residents (and their family) are provided with this information at the point of entry. Interpreters are available through the DHB if required. There have been no residents who require interpreting services in the time the clinical nurse manager has been with the service. D11.3 The information pack is available in large print if required and advised that this can be read to residents.  Six of six residents interviewed and one family member interviewed state that there is excellent communication with the clinical nurse manager and other staff.  The family member states that they are informed when there is an incident and the incident forms reviewed (10 of 10 reviewed) reflects this. |

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

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

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| D13.3h. The service has complaints management policies and procedures in place and residents are provided with information on the complaints process on admission through the information pack. D13.3g: The complaints procedure is provided to relatives on admission as confirmed by the family member interviewed. The complaint process is in a format that is readily understood and accessible to residents/family.  Staff including the clinical nurse manager, two caregivers and registered nurse interviewed are aware of the complaints process and to whom they should direct complaints. Residents and family confirm they are aware of the complaints process and they would make a complaint to the manager if necessary.  Six of six residents including one under the continuing care contract interviewed and the family member state that they have no complaints nor have they had the need to complain about anything in the past.  There is a comprehensive complaints register in place. One complaint reviewed in 2013 is documented on the complaints register and indicates that resolution and a letter to the complainant has been completed in a timely manner. The clinical nurse manager confirms that there have been no complaints in the past three years with the Health and Disability Commissioner, MoH or DHB. |

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

## **Outcome 1.2: Organisational Management**

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| Torbay Rest Home provides care for up to 42 rest home residents. At the time of the audit, there are 38 residents including two requiring respite care.  The clinical nurse manager has been in the position for a year (since October 2012) and has over 18 years prior experience in aged care including management experience; work in psychogeriatric and dementia units. The clinical nurse manager is supported by a registered nurse who has a current APC who works 20 hours a week.  ARC, D17.3di (rest home): The clinical nurse manager has maintained at least eight hours annually of professional development activities related to managing a rest home.  All six residents and family praised the leadership and operational management of the clinical nurse manager.  The organisation mission is " to provide a quality, homely environment in which the frail elderly ( and or confused elderly) may live in an atmosphere of respect and friendliness and have their physical and psychological needs met". The mission statement is included in pre - entry information that is given to prospective residents and there is a website that describes the service as being ‘designed to meet the needs of the residents and provide an attractive pleasant and safe environment’. |

##### **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:** PA Low |
| **Evidence:** |
| D19.1a; A review of the documentation, policies and procedures and from discussion with the clinical nurse manager, two caregivers and registered nurse interviewed identifies that there are service operational management strategies which includes individually appropriate care. The clinical nurse manager provides oversight of the quality programme with oversight from the owners.  The policies and procedures are documented and have been reviewed in 2012-2013. There is a document control process in place for all policies.  D5.4 The service has the following policies/ procedures to support service delivery; continence, challenging behaviour, pain management policy and procedure, personal grooming and hygiene policy, skin, wound care policy and procedures, transportation policy and procedure. D10.1 There is a death policy and procedure that outlines immediate action to be taken upon a resident death and that all necessary certifications and documentation is completed in a timely manner. The clinical nurse manager, two caregivers and registered nurse interviewed state that any new caregiver receives an orientation that includes reading of the policies - orientation records signed off in all five staff files reviewed.  The service has an implemented internal audit programme. When staff meetings occur (note that these are not always regularly held as scheduled), then most aspects of the quality and risk management programme is discussed with data presented. This includes infections and infection control, complaints, incidents and accidents, staff, resident issues. There used to be a restraint approval group meeting (last held in 2011) however, this is no longer held and restraint is not an agenda item at the staff meetings.  Resident meetings are held six monthly and family are invited to attend.  There is a risk management register and hazards documented. A review of these indicate that these are signed off when resolved. A list of current hazards is kept with actions implemented to assist with preventing further accidents. Residents and family receive a newsletter at times throughout the year.   D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management D19.2g Falls prevention strategies such as increased supervision is used.  Residents and family interviewed can describe improvements in the service over the past year. Improvements in 2013 have included the following: refurbishment of the inside and exterior of the building, integration of files, employment of an activities coordinator, van rides for residents twice a week and use of a volunteer art therapist.   Improvements are required to the quality programme including implementation of the resident and family satisfaction survey, documentation of corrective action plans when issues arise with evidence of resolution, restraint as a regular agenda item at the staff or other meeting and regular staff meetings held. |

##### **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):**  *(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.

|  |
| --- |
| **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 1.2.3.4 (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):**  *(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.

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a staff meeting that is expected to be held monthly with most aspects of the quality programme discussed. A restraint approvals group meeting was held in the past – last held in 2011 |
| **Finding:** |
| Staff meetings are held irregularly throughout the year and restraint is not a set agenda item. |
| **Corrective Action:** |
| Ensure that staff meetings are held regularly throughout the year as scheduled with restraint included as an item for discussion. |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.3.6 (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):**  *(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.

|  |
| --- |
| **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 1.2.3.8 (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:** PA Low |
| **Evidence:** |
| The clinical nurse manager and registered nurse are familiar with the expectation that corrective actions and evidence of resolution should be documented. |
| **Finding:** |
| Corrective actions and evidence of resolution are not documented when issues arise. |
| **Corrective Action:** |
| Document corrective actions with evidence of resolution. |
| **Timeframe (days):** 90 *(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.

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| D19.3b; There is an incident and accident policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.  Incidents/accidents are investigated and analysis of incidents trends occurs through discussion at staff meetings (refer 1.2.3.5). The clinical nurse manager provides oversight of all incidents and accidents and 10 of 10 reviewed show that these are signed off by the clinical nurse manager. Discussions with the clinical nurse manager and the registered nurse confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.  There is an open disclosure policy and the family member interviewed states they are informed of changes in health status. A review of 10 incident forms indicate that family have been informed.  The clinical nurse manager states that notification of authorities has not been required for any incidents since the clinical nurse manager’s employment. |

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Five staff files were reviewed including the registered nurse and two caregivers.  D17.7d: There are implemented medication competencies for all relevant caregivers and registered nurses (seven in total) and evidence in staff files confirms that these have been completed for relevant staff.  Current practicing certificates are sighted for the clinical nurse leader, registered nurse, doctors, dietitian and physiotherapist.  Five of five staff files include a signed contract, application form, evidence of training, referee checks and job description. The service does not obtain police checks. Five of five files reviewed indicate that staff have completed an orientation programme that is relevant to support for people using rest home level care with the service having a low turnover rate of staff. Three caregivers have completed ACE programme and four are currently enrolled.  The clinical nurse manager and registered nurse confirm that they have completed at least eight hours training a year (training records sighted).  Six of six residents interviewed and one family member state that staff are competent, caring and knowledgeable. There is an annual training plan and two caregivers confirm that they find the training valuable. There are individual staff records of training.  Three of five staff files reviewed include annual performance appraisals.  An improvement is required to performance appraisals. |

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

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

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

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Three of five staff files include a current and annual staff performance appraisal. |
| **Finding:** |
| Two of five files do not include a current annual staff performance appraisal. |
| **Corrective Action:** |
| Ensure that all staff have a current performance appraisal annually. |
| **Timeframe (days):** 180 *(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:** |
| There is a staffing policy. It is sufficiently detailed to ensure that there is appropriate staff to safely meet the needs of residents.  There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.  The service contracts with allied health professionals on an as required basis.  There are a total of 39 staff including the clinical nurse manager, registered nurse (20 hours a week), an activities coordinator (18 hours a week), two cooks, seven tea staff to help with meals, a maintenance staff, two laundry and two cleaners (five days a week), 21 caregivers.  Staffing is as follows (38 of 42 residents): AM: Four caregivers (one from 6am-12am and three from 7am-1pm); one team leader 7.30am-4pm.  PM: Two caregivers (one from 1pm-9pm and one from 3pm-11pm).  Night: Two caregivers from 11pm-7am.  Staff are replaced if they are away as sighted on four previous rosters reviewed.  Six of six residents interviewed report there are always enough staff on duty and all praised the staff for the care and support provided.  Staff turnover is low. |

##### **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:** |
| D16.2, 3, A registered nurse / clinical nurse manager (registered nurse) completes the assessments on admission, with the initial care plan completed within 24 hours of admission. Within three weeks, the long-term care plan is developed as evidenced in five rest home resident files sampled.  There is evidence of resident and/or family involvement in the care planning process.  The activities coordinator completes an activities assessment involving the resident and their family soon after admission.  Care plans are used by staff including caregivers to ensure care delivery is in line with the residents assessed needs.  A range of assessment tools available for use on admission include (but not limited to); a) dietary profile b) Braden pressure area risk assessment, c) continence assessment d) coombes falls risk assessment and fall risk assessment tool e) wound assessment f) pain assessment and g) disturbing behaviour assessment. All include a falls assessment, pressure area assessment and mini nutritional assessment and others are used at times.  There is a verbal handover for caregivers at the beginning of each shift. Any resident concerns or events are communicated to the oncoming staff as observed during the handover on the day of the audit. Caregivers state that the verbal handover at the beginning of each duty that maintains a continuity of service delivery.  All five resident files identified integration of all information apart from medication administration sheets.  The general practitioner identifies frequency of visits in medical notes. The five files show that the general practitioner has seen the resident within 48 hours of admission and at least three monthly (refer 1.3.12).  Care plans include a cultural assessment and cultural needs with interventions documented for the Maori resident reviewed.  The GP was unavailable for interview.   Tracer methodology; Rest home resident  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  An improvement is required to the use of specialised assessment tools when required. |

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| A range of assessment tools available for use on admission include (but not limited to); a) dietary profile, b) Braden pressure area risk assessment, c) continence assessment, d) Coombes falls risk assessment and fall risk assessment tool, e) wound assessment, f) pain assessment and g) disturbing behaviour assessment. All include a falls assessment, pressure area assessment and mini nutritional assessment and others are used at times. |
| **Finding:** |
| Specialised assessment tools are not used at times when changes in care needs requires further investigation e.g. pain assessment for one resident with continued back pain, dietary assessment for one resident with weight loss. |
| **Corrective Action:** |
| Document and use specialised assessment tools when required. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| Residents' support plans are completed by the clinical nurse manager and registered nurse. When a resident's condition alters, the clinical nurse manager initiates a review and if required, GP or specialist consultation.  The registered nurse, two caregivers and clinical nurse manager interviewed state that they have all the equipment referred to in support plans necessary to provide care, including a pressure area mattress, lifting belts, mobility aids, gloves, aprons and masks.  The service has access to physiotherapy services for equipment assessment and advice.  D18.3 and 4 Dressing supplies are available and the treatment room is well stocked. Staff report that there are adequate continence supplies and dressing supplies.  Five resident files were reviewed:  XXXXXX *This information has been deleted as it is specific to the health care of a resident.*  An improvement is required to documentation of short-term care plans or wound management plans when skin tears are noted and to documentation of adequate and appropriate strategies/interventions to address issues identified (weight loss and back pain). |

##### **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:** PA Moderate |
| **Evidence:** |
| Interventions are documented in care plans for most issues identified for residents through assessments (refer 1.3.3.3) and care plans. |
| **Finding:** |
| (i)Wound management plans or short-term care plans are not documented for residents with skin tears. (ii) Interventions are not adequately documented in the care plan or in short term plans for weight loss and back pain. |
| **Corrective Action:** |
| Ensure that care plans document specific care and interventions for the following: (i) Wound management plans or short-term care plans for residents with skin tears. (ii) Interventions the care plan or in short term plans for weight loss and back pain. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The service employ an activities coordinator for 18 hours a week with an activities programme documented. The programme is planned to suit the resident’s recreational, spiritual and cultural needs and physical and cognitive abilities. There is a residents meeting held six monthly with good feedback and suggestions for activities, outings and entertainment. The programme is displayed in the facility. There is an art therapist who volunteers on a weekly basis. Residents are encouraged to remain as independent as possible with one to one activities provided. Activities include housie, cards, on site shop, outings twice a week, games, crafts, reading. Residents interviewed, if involved in the programme, state that they enjoy it and the appointment of the activities coordinator has been an improvement in the service. |

##### **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 Care plans are evaluated six monthly more frequently when clinically indicated. The clinical nurse manager or registered nurse completes the review of the long-term care plan. Changes to health status or additional support required is entered onto a short-term care plan as sighted in some files (refer 1.3.6) and onto the care plan.  The resident/family are notified of the review and invited to attend.  The long-term support plan is amended with each review if there are changes.  The GP reviews the resident three monthly including reviews of the resident’s weight, blood pressure and pulse and any concerns the clinical nurse manager or resident/family wish to discuss.  ARC D16.3c: All initial care plans are evaluated by the RN within three weeks of admission with the long-term care plan documented in this time. |

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| All the four weekly blister packs and pharmaceuticals are delivered by the pharmacist and checked by the registered nurse or clinical nurse manager. Any discrepancies are fed back to the pharmacy.  The clinical nurse manager or registered nurse returns unwanted/expired medications to the pharmacy and the pharmacist countersigns the returns.  There is a signing register for registered nurses and caregivers responsible for the administration of medication. The clinical nurse manager, registered nurse and caregivers receive annual competency assessments.  A weekly stocktake is completed on all controlled drugs kept in the safe. There is one resident using fentanyl patches and these are documented appropriately.  Medication is kept in a locked area.  Approved sharps containers are used for the safe disposal of sharps.  There are no standing orders in use.  There are no residents self-administering medications.  Ten of 10 medication charts sampled had photo identification and allergies/adverse reaction noted as applicable. All have administration signing sheets completed correctly for regular and prn medications.  D16.5.e.i. 2, There is evidence of three monthly general practitioner reviews of medications in eight of 10 files reviewed. The sample of medication files was increased by two. Eight of 12 medication forms show three monthly reviews by the general practitioner.  An improvement is required to review of medications by the general practitioner in a timely manner. |

##### **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):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is evidence of three monthly general practitioner reviews of medications in eight of 10 files reviewed. The sample of medication files was increased by two. Eight of 12 medication forms show three monthly reviews by the general practitioner. |
| **Finding:** |
| Four of 12 files do not show that the general practitioner has reviewed medication three monthly. Clinical notes documented by the general practitioner reviewed evidence review of the resident at least three monthly however notes do not indicate that medication has been specifically reviewed as part of the consultation. |
| **Corrective Action:** |
| Ensure that there is documentation that indicates that the general practitioner has reviewed medication at least three monthly. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

|  |
| --- |
| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There are two cooks who cook all meals with staff serving food and supporting residents as required. One cook has completed City and Guild training and the other is a Thai chef with food safety training completed.  The menu is a winter/summer rotation with the main meal at midday. Residents provide feedback and suggestions on the menu verbally and through the resident meetings. Residents interviewed are very happy with the meals.  The cook receives a resident dietary profile for each new admission and if there are changes to meal requirements. Likes and dislikes are known and alternatives offered. Vegetarian and gluten free diets are catered for and the cook can describe providing extra calories for one resident to help the resident to gain weight. The cooks bake daily for AM and PM teas. There are special spoons and plates for those who need them.  The meal observed indicates that the food is served hot with adequate servings for each resident. Residents are encouraged to take their time with their meal.  There is a large storeroom with enough stock to last for three days at least in the event of an emergency. Fridges are monitored weekly. Chemicals are stored safely.  D19.2 Staff have been trained in safe food handling as part of infection control in 2013.  An improvement is required to monitoring of freezer temperatures. |

##### **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:** PA Low |
| **Evidence:** |
| Fridge temperatures are monitored weekly. |
| **Finding:** |
| The two freezers are not checked to ensure that temperatures are in the appropriate range. |
| **Corrective Action:** |
| Ensure that freezer temperatures are within normal range as per policy. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** 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 1.4: Safe and Appropriate Environment**

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The facility has a current building warrant of fitness that expires 30 June 2014.  There is a preventative maintenance programme in place, which includes regular scheduling, and checks on all building, plant and equipment  When an issue requiring maintenance occurs staff document this in the maintenance book, which is held in the office, the requests are checked and repaired by the maintenance person or an external contractor. The maintenance book was sighted and includes date of requests with date of completion signed off.  Electrical equipment is recorded, checked and tagged annually by an electrician.  Six monthly fire drills occur with the most recent held August2013.  Residents are observed moving freely about the home and accessing the communal areas with ease.  ARC D15.3; There is adequate equipment available for the rest home. There is seating and shade with paths and grounds that are able to be accessed by residents. |

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

All buildings, plant, and equipment comply with legislation.

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

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

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

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

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

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

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

# 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:** |
| The policy around restraint and enablers is applicable to the type and size of the service (rest home). The service has a restraint free philosophy.  Restraint is not used and there are currently no enablers used. The policies and procedures are comprehensive, including definitions, processes and use of enablers. The policy includes that enablers are voluntary and the least restrictive option. Strategies are in place to minimise the use of restraint including mobility aids and supervision of residents. Two caregivers and clinical nurse manager interviewed confirm knowledge of restraint, enablers and management of challenging behaviours and staff have completed training around restraint, enablers and challenging behaviour in November 2013. |

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

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

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

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

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

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

|  |
| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The surveillance programme is outlined in policy and is determined by the infection control coordinator (registered nurse, clinical nurse manager with input/oversight from the directors).  An individual infection sheet is completed and the registered nurse (infection control coordinator) confirms that this is used for individual clinical care.  There is a monthly infection summary report completed and the information is graphed monthly and presented at the staff meetings (refer 1.2.3) with trends reviewed six monthly.  Staff interviewed including the two caregivers and registered nurse state that the information is useful in enabling them to care for residents with infections better.  The surveillance of infection data assists in evaluating compliance with infection control practices and any changes lead to outcomes to improve service delivery.  There are audits to ensure that there is appropriate infection control and this includes the resident care hygiene audit (last completed September 2013), infection control and hand washing audit (October 2013). |

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

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

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

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

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

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